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THE EXPERIENCE OF POSTNATAL DEPRESSION IN A SAMPLE OF ROMANIAN MOTHERS

ANDREEA BARBU[1*], OANA BENGA[2]

ABSTRACT. Maternal postnatal depression (PND) is a prevalent condition after birth, with significant effects on both mother and child mental health. The aim of the present research was to explore the experience of postnatal depression in a sample of Romanian mothers. Within an interpretative-phenomenological approach, we interviewed and analyzed the data from three mothers, regarding their perception and experience of postnatal depression. All participants were screened for PND in the first place. Within the interviews, three major themes were delineated: 1) postnatal depression: experience, significance, contextualization; 2) ambivalence; 3) social support. Three specific themes also emerged: 1) worries and dysfunctional cognitions; 2) family conflict; 3) dissatisfaction with self. All three mothers recognized the concept of postnatal depression and knew its meaning. The meanings assigned by the mothers to postnatal depression, respectively to their psychological states were: disorder, tendency to harm the baby, sadness, apathy, dissatisfaction with self. Mothers' perception of their PND experience was ambivalent, changing from minimization or denial to acknowledgment. Social support was perceived as present, while emotional support was also acknowledged as understanding (of mothers' experiences). Our results depicted postnatal depression as a phenomenon experienced both in rural and urban contexts, with common and specific features among participants.

Key words: *postnatal depression, mothers, experience, qualitative research.*

ZUSAMMENFASSUNG. Die Erfahrung der postnatalen Depression in einer Stichprobe von rumänischen Müttern. Mütterliche postnatale Depression (MPD) ist eine verbreitete Erkrankung nach der Geburt, mit erheblichen Auswirkungen auf Mutter und Kind psychische Gesundheit. Das Ziel der vorliegenden Studie war die Erfahrung der postnatalen Depression in einer Probe der rumänischen Mütter zu erkunden. Innerhalb eines interpretativ-phänomenologischen Ansatzes haben wir die Daten von drei Müttern in Bezug

[1] Department of Psychology, Faculty of Psychology and Sciences of Education, Babeș-Bolyai University
[2] Department of Psychology, Faculty of Psychology and Sciences of education, Babeș-Bolyai University
[*] Corresponding author: E-mail: andreeabarbu@psychology.ro

auf ihre Wahrnehmung und Erfahrung der postnatalen Depression interviewt und analysiert. Alle Teilnehmer wurden in erster Linie auf MPD geprüft. Innerhalb der Interviews wurden drei Hauptthemen abgegrenzt: 1) postnatale Depression: Erfahrung, Bedeutung, Kontextualisierung; 2) Ambivalenz; 3) soziale Unterstützung. Es gab auch drei spezifische Themen: 1) Sorgen und dysfunktionale Kognitionen; 2) Familienkonflikt; 3) Selbstunzufriedenheit. Alle drei Mütter erkannten das Konzept der postnatalen Depression und wussten ihre Bedeutung. Die Bedeutungen zugewiesen von den Müttern zur postnatalen Depression bzw. zu ihre psychologischen Zustände waren: Störung, Tendenz dem Baby zu schaden, Traurigkeit, Apathie, Selbstunzufriedenheit. Die Wahrnehmung der Mütter in Bezug auf ihre MPD-Erfahrung war ambivalent und wechselte von der Minimierung oder der Ablehnung der Anerkennung. Die soziale Unterstützung wurde als Gegenwart wahrgenommen, während die emotionale Unterstützung war auch als Verständnis (der Erfahrungen der Mütter) anerkannt. Unsere Ergebnisse zeigten eine postnatale Depression als ein Phänomen, das sowohl im ländlichen als auch im urbanen Kontext auftritt, mit gemeinsamen und spezifischen Merkmalen unter den Teilnehmern.

Schlüsselwörter: *postnatale Depression, Mütter, Erfahrung, qualitative Forschung*

INTRODUCTION

Affective disturbances in the postnatal period can be differentiated into 1) postnatal blues or baby blues – a mild intensity and temporary state, with onset in the first three to five days after birth (Nobel, 2005, Wisner, Parry, Piontek, 2002); 2) postnatal depression; and 3) postpartum psychosis – an acute disturbance, beginning in the first two to four weeks after birth (Sit, Rothschild, & Eisner, 2006). With a proportion of affected mother estimated around 10–15%, postnatal depression (PND) is considered a prevalent mental health complication after childbirth (O'Hara & McCabe, 2013, Robertson, Celasun, & Stewart, 2003). This condition (PND) may be characterized by sadness or depressive disposition, crying, fatigue, sleep/ appetite/ weight disturbance, suicidal ideation, thoughts of harming the baby and infanticide in extreme cases. It is included in the cluster of affective disorders, like major depression with postnatal onset - in the following four weeks after delivery (American Psychiatric Association, 2013). According to a recent conceptualization, for example, this condition represents "any major or subsyndromal depression present any time during the first year after birth" (O'Hara & McCabe, 2013, pp. 380). Generally, as we described above, the symptomatology is supposably similar to major depression diagnosed at any other time in life (O'Hara & McCabe, 2013).

Postnatal depression is an important topic for research and practice (O'Hara & McCabe, 2013) since it affects the mother, the infant and the parental couple (Beck, 2002, Grace & Sansom, 2003, Robertsonet al., 2004, Bliszta et al., 2010). Many women experience postnatal distress, even if not at a clinical level of depression. This happens as giving birth represents a considerable stressor, a new and complex life event. Therefore, it is possible that this stressor will produce affective disturbances (Cooper & Murray, 1995, Robertson et al., 2003). In other words, postnatal depression is affecting mothers by predisposing the ones without a history of depression to subsequent postnatal depression episodes. Moreover, for mothers with a history of depression, PND could lead to recurrence of depressive episodes outside the perinatal period (Cooper & Murray, 1995, O'Hara & McCabe, 2013). Regarding the ongoing experience of motherhood after giving birth, PND appears to affect in a negative way mother's emotional state (e.g. elevated levels of distress or negative emotions), caregiving practices (e.g. problems with breastfeeding, improper car safety practices for the infant) and parenting (e.g. reduced synchrony in dyadic interactions and increased irritability and hostility) (Field, 2010; Lovejoy, Graczyk, O'Hare, & Neuman, 2000; O'Hara & McCabe, 2013). Postnatal depression also influences cognitive processes. For example, depressive symptoms were shown to be associated with reduced attention in dyadic interaction and negative appraisal of infant's behavior (Dix & Meunier, 2009). We will further discuss mothers' perspectives on PND experience in the following section.

The adverse effects that postnatal depression has on the infant via mother-infant interaction are supported by numerous studies (Grace & Sansom, 2003, Field, 2010, O'Hara & McCabe, 2013). In their meta-analysis, Grace & Sansom (2003) show that postnatal depression has a negative effect on mother's communicative behavior – reduced verbal and visual interaction, and upon mother's affect towards the infant – less positive interactions, less sensitivity. The impact of postnatal depression on infant development can be found at various levels: emotional, cognitive and behavioral (Grace & Sansom, 2003, Grace, Evindar, & Stewart, 2003). We briefly point here to effects on infants' attachment. There is an increased risk for children of mothers with postnatal depression to develop an insecure type of attachment (i.e., anxious or avoidant), than for children of non-affected mothers (Wisner, Parry, Piontek, 2002, Grace & Sansom, 2003). At the couple level, postnatal depression can generate conflicts or tension, due to the difficulties mothers encounter in managing their new maternity responsibilities (Bilszta et al., 2010).

Kumar (1994) outlined the fact that pregnancy and childbirth are common events around the world, having the same physiology. However, the experience and perception of these phenomena can vary among mothers and

their social groups (Kumar, 1994, pp. 251). Another way to highlight this fact is through Beck's (2002) analogy of postnatal depression with a chameleon: it might have the same organic or physiological structure, but can have distinctive manifestations and experiences. For example, Hall (2006) reported that the experiences of women she investigated were characterized by difficulties in speaking about their condition, believes that peers will not understand them, perceptions that they were bad mothers, worries about bonding and their mother-infant relations. Moreover, their expectations for a good or happy postnatal experience were disconfirmed by the experience after giving birth (Hall, 2006). Postnatal depression experience was described by mothers interviewed in different studies as a phenomenon of morbid unhappiness after giving birth (Oates et al., 2004) or an experience of major adaptation which often was exhausting (Buultjens & Liamputtong, 2007). Mothers' descriptions of their emotional experience were consonant with at least some of the DSM criteria for depression: fatigue, lack of energy, worthlessness, guilt (see Ugarizza, 2002).

One result we consider important is that of Bilszta et al. (2010), who found that mothers were not aware of their psychopathological conditions since they were conceptualizing depression only in terms of severe manifestations (e.g. not being able to get out of bed or physically function). Women often did not access mental health services, due to this impercipient awareness, but also due to lack of knowledge about specialized aid (Bilszta et al., 2010). Mothers also reported difficulties in telling others about their experiences, because of social stigma, either real or imagined (Hall, 2006, Bilszta, 2010). These difficulties might be explained by mothers' beliefs that nobody could understand them (Hall, 2006) or by the fact that they did not want to be perceived as failures, but to preserve instead an image of capable women that successfully manage maternity challenges (Bilszta et al., 2010). A revolving theme in qualitative studies on postnatal depression refers to expectations regarding various aspects of postnatal life; for example, mothers expected to be able to cope better with maternal duties or with the baby, they expected maternity to be an easier phase compared to how it was in reality (Beck, 2002; Buultjens & Liamputtong, 2007; Hall, 2006).

Another important theme in the research devoted to postnatal depression is social support. Regarding this, Bilszta et al. (2010), for example, showed that resistant attitudes towards PND displayed by family members altered women's help-seeking behavior and the acceptance of their emotional experience. Regarding mothers' perceptions of social support, this is often seen by mothers as being inadequate, either emotionally or instrumentally (Buultjens & Liamputtong, 2007). Moreover, the perceived lack of social support

is reported by mothers to be a contributing factor to their postnatal sadness (Oates, 2004). Mothers interviewed by Buultjens & Liamputtong (2007) described disagreements with husbands or their own mothers, along with infants' negative reactivity (e.g. cry or agitation) and contradictory advice from others, as main psycho-social factors related to their disturbed state.

Also, interesting to note is one result of Oates et al.'s (2004) transnational study, referring to "the term postnatal depression". In most of the countries included in this study (i.e. France, Italy, Sweden, Austria, Japan, United Stated of America), mothers freely named their state of morbid unhappiness after childbirth using the phrase 'postnatal depression'. On the other hand, this phenomenon was denied by Australian mothers in Bilszta et al.'s study (2010) (i.e. mothers reported that they cannot experience PND, this state cannot happen to them). This pattern of results could indicate some cultural differences that mark the recognition and use of the concept 'postnatal depression.'

Beck (2002) synthesized the phenomenon of postnatal depression, after analyzing several qualitative studies, in the following themes: internal conflicts between expectations and the experience of motherhood; feeling overwhelmed, anger, anxiety, guilt, loneliness, pervasive loss, which follow a pattern of "spiraling downward"; cognitive patterns of obsessive thinking, impairment in cognitive capacities, thoughts of harming oneself. Postnatal depression can also affect women's experiences with their infants, in the sense that, later in their children's development, mothers can feel they missed out on the first period of their children's life (Beck, 1999, Beck, 2002).

The present study

Despite its effects and implications at the individual, micro- and macro-social levels, postnatal depression remains largely "underdiagnosed" and "undertreated" (Stewart, Robertson, Dennis, Grace, & Wallington, 2003). As such, research should examine postnatal depression and its consequences in diverse ethnic and socioeconomic groups (Stewart et al., 2003, pp.4).In order to address postnatal depression, authors posit that it is necessary to become familiar with mothers' experiences, specifically to understand the perception and significance they assign to this condition (Dennis & Chung-Lee, 2006, Ugarizza, 2002). Denis & Chung-Lee (2006), proposed the idea that, to be addressed, childbirth and maternal depression should be understood in relation to a specific cultural background, reflected in the ways mothers conceptualize and explain their symptoms. In line with this, our research question focused on the experience of postnatal depression. Thus, we wanted to make a contextualized analysis of this phenomenon, exploring the experiences of postnatal depression in a sample of Romanian mothers.

METHOD

Participants

Out of 46 participants recruited for PND screening in the preliminary phase of the study, five mothers met the criteria for inclusion. Only three of them accepted to be interviewed (See Table 1, for participant information). The study took place in a couple of urban and rural settings from Cluj and Alba counties. The inclusion criteria were: 1) the age of the infant – which was in the 1 to 12 months age range; 2) the scores for the two screening questionnaires (i.e. BDI-II and EPDS). For the Beck Depression Inventory –II (BDI-II) the cut-off score recommended and considered suitable for primiparae mothers in an early postnatal period is 10, while for primiparae mothers in a late postnatal period is 12.A BDI-II cut-off score of 15 is recommended in case of multiparae mothers, both for early and late postpartum periods. For the Edinburg Postnatal Depression Scale, a minimum score of 11 is recommended for primiparae mothers in the early periods and for multiparae mothers both for early and late postnatal periods, while for primiparae mothers in a late postnatal period 13 is the optimal cut-point(Ji, Long, Newport, Na, Knight, Zach, Morris, Kunter, & Stowe, 2011). The reasons for choosing the infant age criterion of 1 to 12 months are the following: 1) literature recommends taking into account the interval 1 to 12 months postnatally for the onset of postnatal depression (Robertson et al., 2003); 2) inclusive age limits are needed, in order to provide an accurate and detailed investigation of the phenomenon.

Table 1. Participant information

Participant	Maternal age	Infant age	Number of children	Marital status	Educational level
P1	33 years	10 months	2	Married	Vocational school
P2	33 years	8 ½ months	2	Married	Vocational school
P3	21 years	2 months	1	Married	High school

Instruments

Beck Depression Inventory – II (BDI-II, Beck, Steer & Brown, 1996) is a scale designed for measuring the severity of depression in general and clinical populations. It comprises 21 items, each evaluating a specific symptom or

attitude of depression. The inventory has good psychometric properties in the clinical and non-clinical samples from Romania: Cronbach α = .90 for the clinical, respectively Cronbach α = .89 for the non-clinical sample; a validity coefficient r=.72 with Hamilton Rating Scale for Depression (adapted by David & Dobrean, 2012).

Edinburgh Postnatal Depression Scale (EPDS, Cox, Holden, Sagovsky, 1987, Wisner, Parry, Pointek, 2002) is the most used instrument for measuring postnatal depression. It is highly correlated with clinical evaluations (Cox et al., 1987). Cox et al. (1987) report a fidelity coefficient Cronbach α = .87. The good psychometric properties of the scale have also been shown by other studies: Gaynes et al. (2005), Matijasevich et al. (2014). We conducted a process of translation and retroversion for this scale. In the process of translation, three psychologists took part. The retroversion was done by two other psychologists. All of them are native Romanian speakers and independent English speakers. The fidelity of the instrument in our sample (N=46) is good: Cronbach α = .79.

A semi-structured interview was used for investigating the experience of mothers with postnatal depression symptomatology. The interview was designed following the guidelines of Baban (2002), Smith & Osborn (2003), Patton & Cochran (2002). This method is considered an adequate one in doing interpretative phenomenological analysis (Chapman & Smith, 2002). The interviews consisted of general questions, on topics like the current experience, difficulties encountered in the postnatal period, the significance of the current experience/postnatal depression for the mother, the experience of maternity.

Procedure

Participants were recruited via general practitioners (GP) and their nurses. First, the announcement of the study was disseminated. GPs, nurses, and mothers were informed that the study regarded maternal wellbeing and maternal adjustment after birth; GPs, nurses or the researcher obtained the verbal agreement of mothers for participation. In the preliminary phase, participants were screened for the presence of postnatal depression symptomatology. All participants received an informed consent, previously to answering the questionnaire. The screening session took place in various settings: the GP's office, mothers' homes, at Babeș-Bolyai University. The screening sessions were organized as a group or individual sessions, depending on mothers' availability. In either case, only the mother(s) and the researcher were present in the room. The GPs and the nurses did not attend any of these sessions. For the next phase, the researcher called the mothers and invited them to a discussion based on the questionnaire they filled in. Mothers received a

consent form again, with explicit information about the procedure of audio recording the interview. All mothers agreed. The interviews were organized as individual sessions. The length of the interviews was about 40 minutes. We conducted interviews from the interpretative-phenomenological perspective (IPA), with general questions followed by in-depth inquiries (Smith, 2004). In other words, the data collection was guided but flexible, to bring to light participants' answers and experiences (Smith & Osborn, 2003). At the end of this phase, we explicitly discussed with mothers the objective of the study and also the results obtained from the questionnaire.

Data Analysis

The interviews were recorded and transcribed entirely afterward. The data were analyzed from an interpretative-phenomenological perspective (Smith & Osborne, 2003, Baban, 2002). The process of reading, re-reading and commenting, identifying initial themes, connecting themes and developing thematic clusters was repeated for each interview independently (Smith & Osborn, 2003). In the end, we searched for the common themes through an iterative process. The common themes or the superordinate themes were established relative to their relevance for the research question and to their informational richness. We identified specific themes, based on differences in the cases explored. The process of coding and identifying themes was inductive and deductive. It was inductive because it was highly based on participants' data. It was also deductive, as we were guided by the theoretical issues emerging from literature.

RESULTS

First theme: postnatal depression: experience, significance, contextualization

Three major common themes emerged from the interviews: 1) postnatal depression: experience, significance, contextualization; 2) ambivalence; 3) social support. The first theme referred to postnatal depression: the experience of depression, the significance of depression in the postnatal period and the integration of this experience in the social context. Mothers' descriptions of their emotional state revealed sadness, nervousness, irritability, fear, fatigue, emotional discomfort. The common emotion for all three participants was sadness. For example, the first participant describing her experience said:

> "Well, after I gave birth, I had a period when I was very sad. I was, how can I tell you? I was crying about everything. Even if, I don't know, (for) nothing …. I felt like crying…" (P1).

Moreover, the first and second participants spoke about their inability to relax. They (P1 and P2) confessed that even when other members of the family took care of the child (e.g., the husband or the grandmother), they could not rest, as they were continuously worried about the infant and the carer's ability to manage him/her. They even confessed that they were having doubts their family members could care for the baby as good as themselves.

We observed in all three cases that participants had difficulties in describing their states. They acknowledged they were not feeling well, but in-depth interviewing was needed in each case, to describe the quality of the depressive experience explicitly. Crying was the most reported behavioral expression. The behavior was more accessible to a verbal explanation than the emotion per se. Furthermore, fatigue was repeatedly mentioned by mothers. As it could be expected, this psychosomatic state was exacerbated by the prolonged maternal duties.

Two of the mothers provided antagonistic descriptions when we asked about their perceptions regarding own states and emotions from the prenatal period. In the first and third cases, the descriptions of the prenatal period referred to being active (P1), energetic (P3), "in a very good mood" (P1) and "always smiling" (P3), while the ones of the postnatal period specified states like "very sad" (P1), "not in the mood" (P3) and tired (P3). The second participant, on the other hand, presented her states and emotions as being continuous in the prenatal and postnatal periods. Specifically, she mentioned a tendency towards worrying, fears and "thoughts." She also confessed that her ongoing state was amplified: "I mean there are additional fears (now), but otherwise, I was the same as (I am) now..." (P2).

All mothers were familiar with the term "postnatal depression." Participants did not use the term freely to designate their state. Only when they were asked about knowing the phenomenon of postnatal depression, they answered affirmatively. The question was introduced subsequently to mothers' descriptions of their experience, and it was addressed approximately at the end of the interview, in order not to influence mothers' talk about their experience. An interesting finding about the concept of postnatal depression was the significance mothers assigned to it. We highlight the fact that, when talking about the meaning of this condition, mothers identified their emotional experience with it and gave personal examples. Thus, the meanings for this pathological state were:

- Depression as a disorder or a tendency to harm the baby: "This depression, I don't know if it is a disorder or what it is, but it's… I was afraid not to, as I told you, not to do something more…/ Like, I don't know, to do something with the baby, to kill him or I don't know what, I don't know… To hit the baby if he cries…" (P1)

- Depression as sadness and apathy: "Maybe this – that you cry very much and you get exhausted and... you don't even feel like taking care of yourself." (P2)

- Depression as sadness and dissatisfaction with body image: "To always be sad after giving birth, or something in your body changes or the way you look after giving birth disturbs you? I think so." (P3)

In other words, postnatal depression is a disorder, with prominent sadness, apathy, and reactions like crying. As we noticed, for P1 the significance revolves around the idea of harming the baby, which may occur in severe cases as the mother herself said. Mothers' conceptualization of this phenomenon included all range of symptoms, even possible severe reactions. The sources reported by mothers as providing information about postnatal depression were: the husband, the Internet, and the television. It was surprising and significant to find out that husbands of all three mothers identified their spouses' condition as postnatal depression. With no exception, mothers said that they had discussed this subject with their partners:

> "…He(the husband, even though he was mainly gone to work) stood beside me because he saw that there was something wrong with me./ I am telling you (things) that I haven't told even to my mother. So only my husband has known, insofar. /…with the husband (I had discussed about postnatal depression), because (I think) everybody talks with the husband first." (P1)

> "Yes, my husband told me (that there was something wrong). I discussed with him and he told me that I might be like this after giving birth... the fact that I don't have that much patience and…I don't like to go out, I mean…I rather stay at home." (P2)

> "My husband told me why I have this state that I do not like how I look, I always say that I (must) lose weight, or that I cry at night, and that I am sadder than usually... He said: 'Well love, this means postnatal depression." (P3)

It appears that, for a daily observer– in our cases the husbands, who regularly saw their partners' manifestations, the symptomatology could not remain hidden. Thus, placing the phenomenon of postnatal depression in the social context, we conclude that in the case of a couple, it is an overt condition. As for the extended family or the micro-social context of the mothers, only the third participant reported talking with her parents about her experience. Moreover, at the level of the community, postnatal depression was a covert

condition. Mothers did not show their state and did not discuss their experience with other persons (e.g., other mothers from the village). At the macro-level of analysis, the main source of information and influence for the conceptualization of the phenomenon was mass-media: internet and television. Mothers said they read information about postnatal depression on the internet or heard news about severe PND cases. Mothers acknowledged the benefits of informational input, but recognized a reduced impact at the personal level: "Well, it is one thing to read, to be informed, but it is only you who know how it feels." (P3).

Second theme: ambivalence

The second theme refers to mothers' ambivalence: i.e. acceptance and denial of their experience. This tendency was most evident in the first case. P1 had repeatedly swung between contradictory affirmations:

> "I can say that now I kind of got well a bit, and the child has grown a bit…/ I am at home all the time. I live in the village, at home…well, it is hard. / I cannot say… No, nothing comes hard to me."

Additionally, the ambivalence or hesitation in identifying postnatal depression can be depicted by the following lines:

"Q: And what do you mean by postnatal depression?

A: This depression, I don't know if it's a disorder or what it is, but it's… I was afraid not to, I've told you, not to do something more (harmful)…

Q: I understand that you are familiar with this term or that you have heard about it. What do you exactly mean by it?

A: Yes, I have heard, of course, that I have heard. And not only have I been, or maybe I have been…or haven't been depressed like this, others may be more (affected)…" (P1)

The other two participants also ambivalently described symptoms of postnatal depression from their experience. They questioned or hesitated to admit the presence of the condition in their cases.

Third theme: social support

Social support is another major theme revealed by the analysis of the interviews. In our opinion, this is an essential theme, as it leads to similarities to, but also differences from other research results. Social support refers to the help mothers receive. The extended family is the major source of support (e.g.: own mother/parents, mother in law, sister) in our study. The first participant even regards the family as the unique source of support. The effective support

from family members consists of: taking the baby from home and caring for him and housekeeping. Emotional support from parents or parents-in-law is less mentioned. It may be due to mothers not expressing or communicating their experience.

> "… (My mother) took the baby for me to rest. With her, I don't talk too much, to tell her that I am sad… I cannot say that I have told her everything, that it is hard with the baby."(P1)

Fathers are seen as an important source of support. The three mothers said they received instrumental support from their husbands'. They help with walking the baby, feeding and putting the baby to sleep (P1, 2, 3), cooking (P3) or doing homework with the older children (P1, P2). Instrumental support can also mean the time the father spends at home. The motif of time comes up without being questioned. Except for the third participant, for the first and second participants, the time their husbands were spending home was tacitly unsatisfactory.

The father was perceived by our participants as having a vital role in offering instrumental and also emotional support. Our third participant expressed clearly her belief about the husband's role:

> "Q: And what kind of help do you think mothers should get after giving birth, maybe at an ideal level?
>
> P3: "To be understood by their husbands. I believe there is not greater help. …Because they did not conceive the baby alone, they (the fathers) should get involved also."

The desired emotional support appeared from the interviews as understanding (of mothers' experiences). For our participants this understanding represented husbands' cognizance of their (mothers') emotional states and difficulties encountered in caring for the baby, respectively in homemaking. As described earlier in the results section, the fathers were aware of the phenomenon of postnatal depression experienced by their wives: "he (the husband) knew there was something wrong with me" (P1).

Specific themes

As we mentioned before, the specific themes that could be delineated from the interviews were: worries and dysfunctional thinking, intergenerational conflicts, dissatisfaction with self. These themes, are relevant since they add distinctiveness to each participant's experience.

First specific theme: Worries and dysfunctional cognition

The second participant's discourse leads to this specific theme. She described herself as always worrying about her health and her children's states:

> P2: "Just that I have these thoughts that if anything should happen, at least it should not happen to the children because I think that I would... I mean I don't usually think 'All is well,' I think 'What if something happens?', 'If' all the time." (P2)

We could also see a negative attributional thinking applied to her life condition:

> "... I am under the impression that everything is going wrong... It's like everybody around me has joy, (but) it seems that I don't have (it)..." (P2)

Second specific theme: intergenerational conflicts

A major subject for the third mother was the conflict with her parents-in-law and her husband's grandmother. P3 thought that the onset of the conflict was the birth of her child. These conflicts were around divergences regarding religious values, parental practices, and beliefs about the maternal role:

> "My mother-in-law taught her (the baby) to stay only, but only in one's arms…. she comes visiting, holds the baby in her arms, carries her, plays with her and you can imagine that if I let her down, she screams from the top of her lungs (and I cannot do anything because of the baby)...And from there came the conflicts because his (the husband's) grandmother says that I am not a woman, that I don't iron clothes, I don't do (household chores)…" (P3)

Third specific theme: dissatisfaction with self

The dissatisfaction was expressed by the third participant. She was dissatisfied with her body and her maternal abilities.

> "I am not satisfied at all with my body. I feel like going insane when I see myself like this in the mirror…" (P3)

Regarding her maternal abilities, this participant said she was expecting to manage more things, because, before giving birth, she was doing many home duties, but at that moment she was not able to do anything more than to care for the child.

DISCUSSION

We started our research by questioning "What is the experience of postnatal depression in a sample of Romanian mothers?" We interviewed three mothers, with infants ranging from 1 to 12 months old, who were screened for PND in the preliminary phase of the study. From the initial group of participants involved in screening for PND, which consisted of 46 women, only five mothers met the conditions described in literature as being necessary for the assumption of postnatal depression. In other words, depressive symptomatology of varying intensity was present in 10.86% of the screened cases. This rate is similar to those found in other studies; for example, Stewart et al. (2003) concluded that this condition affects approximately 13% of women in the first year after birth. One important aspect regarding participation in our study is that two out of the five identified mothers refused to participate in the interview. Moreover, we don't know the real number of persons informed by the medical personnel about our study. The phenomenon of postnatal depression could be a prevalent yet unaccepted condition. It could be the case of minimization or resistance in acknowledging this condition.

Maternal experience of postnatal depression

We have presented in the previous section the manifestations of postnatal depression, as discussed by our participants. These are sadness, crying, fatigue, nervousness, irritability, emotional discomfort, fear, apathy. Our results are in agreement with other findings in the literature; for example, Beck (2002) also mentioned experiences of anxiety, anger, and feeling overwhelmed. We observed that mother's descriptions of their condition were similar to DSM criteria and also to the explanatory model of Ugarizza's (2002) participants. Our participants' symptomatology was similar with DSM-V criteria, as they described sadness, cry, psychomotor agitation, fatigue, lack of pleasure or interest. All participants mentioned states of sadness, nervousness, fatigue. The lack of pleasure or interest was explicitly described only by the second participant. She described herself as having a very low interest for the recreational activities suggested by her husband. For the third mother, activities like watching movies or walking with her husband were present, but they had coping value (e.g., distraction). The first participant, on the other hand, described her daily activities as a routine which consisted of intense and sometimes insurmountable maternal duties. It may be that positive emotions or pleasure/interest for activities are present in moderate or subclinical cases of PND, even though depressive symptomatology may also be present. As the

analysis of interviews showed, mothers mentioned very few pleasant activities, but what they described in fact, were cyclical states. Thus, symptoms of sadness, cry, and apathy alternated with pleasant emotions (e.g. enjoyment of activities with the baby).

Regarding their descriptions of the postnatal experience in comparison with the prenatal period, we saw that participants reported distinctions, but also similarities between the two periods. On the one hand, the description provided by P2 is in line with the risk factors for postnatal depression, as she reported a tendency towards neuroticism (Robertson et al., 2003, Robertson et al., 2004, O'Hara & McCabe, 2013). On the other hand, in the case of P1 and P3, we did not find psychological precursors for depression, when comparing prenatal and postnatal phases. This could be explained by the multiple factors involved in this condition, namely: the stressing experience of motherhood, discrepancies between expectations and reality, difficulties at the level of social support and familial conflicts (Beck, 2002; Buultjens & Liamputtong, 2007; Robertson et al., 2003). The information mothers provided and their experience of being interviewed were in accordance with the husserlian perspective that for a deeper understanding of individuals' experience a scientific approach is needed (Lopez & Willis, 2004).

The meaning of postnatal depression

An important finding of our study is the significance mothers assigned to the phenomenon under investigation. As the analysis showed, mothers were familiar with the term postnatal depression from various sources: the internet, the television. An interesting finding was that partners were the ones conceptualizing mothers' experiences as being postnatal depression. Beck (2002) describes a different phenomenon in her metasynthesis, in that mothers could not talk about their experience, sometimes not even with their partners. In our case, on the other hand, we observed the participation of husbands in recognizing mothers' emotional experience, instead of ignorance or rejection, as revealed by Beck (2002).

The experience of postnatal depression in social contexts

The phenomenon of postnatal depression is shaped in the social context, at various levels. At the couple level, the perception of this phenomenon and its experience are constructed, depending on what is accepted or not. We could thus see the wife who does not cry because her husband does not like to see her doing it. In the extended family, we could find the woman, now a mother, but

also a daughter, who does not discuss her problems with parents. At the community level, we saw that the phenomenon of postnatal depression is largely unspoken. Thus, acceptable and unacceptable topics are socially constructed and shared. At the macro-level, we observed the influence of mass-media (i.e. the television and the internet). These means of information have an influence on mothers' perception or mental construction of the phenomenon. Explicitly, postnatal depression was presented as an illness, a condition which predisposes to acts of harming the baby or of infanticide. The latter is a socially created myth, a similar phenomenon with the myth of motherhood as joyful and gratifying, as Beck (2002) described.

Ambivalence

Further in our analysis, we identified ambivalence as another distinctive theme. This ambivalence refers to swinging between admitting and denying the emotional experience and the difficulties encountered. Listening to mothers' voices, we observed that they were ambivalent regarding their own states and regarding the presence of postnatal depression in oneself. This theme highlights participants' tendency to deny their experience of postnatal depression. If in the beginning, they talked about accommodating to maternal experience and about emotional regulation, further in the interview they acknowledged their negative emotions and difficulties in caring for the baby, yet alternating this acknowledgment with moments of denial or minimization. All three mothers offered contradictory descriptions, but the content of ambivalence differed, as we showed in the results section. The ambivalence could be indicative of a dissonance between the lived experience of postnatal depression and the expectations for easiness and well-being that mothers held prenatally. Mauthner (1998) also identified conflicts and incongruences in mothers' discourses. One type of conflict, evidenced by Mauthner (1998), consisted in this discrepancy between the antenatal expectations for happiness and the postnatal experience of depression. As depicted above, the ambivalence mothers experience could also be generated by the attitudes towards motherhood and PND. Thus, mothers may perceive their experiences are at variance with the expectations or attitudes from the social context or may not fully admit their experiences for fear of social stigma.

Social support

Social support was present and was provided by different sources. It is not only the structure of support that is important, but also the functional dimension of support, which is most relevant for postnatal depression (Leahy-

Warren, McCarthy, & Corcoran, 2011). The support received from the extended family was mainly instrumental. Spatial proximity facilitated the help provided by family members. In two out of the three cases, the young parents lived together with the wife's or husband's family of origin; the other young family lived nearby both the husband's and the wife's parents. Husbands also received credit for offering instrumental support to their wives. The instrumental support was the most evident type of support in mothers 'discourses.

Emotional support is described in the literature as care and comfort (Curtona, 1990, pp. 7). Emotional support appeared for our participants in the form of understanding. Understanding can be defined as fathers' acknowledgment of the mothers' experience of postnatal depression. Understanding is more of a cold cognitive process for our participants. It is different from other conceptualizations of emotional support which imply empathetic, caring attitudes and comforting behaviors. The consequence of this type of emotional support is instrumental support from husbands.

In our study perceived social support was not altered. We consider it could be that the intensity of the symptomatology may be a differentiating factor for the way mothers perceived social support. Another explanation could be through the themes delineated by Bilszta et al. (2010): "not being able to cope/fear of failure" and "stigma and denial." In other words, mothers could have been protecting the positive image of social support they have (theoretically) received and showed satisfaction with it, in order not to prompt negative evaluations or social stigma. How could these mothers admit their own hardships, or the unsatisfactory provision of social support, as long as (with the words of one participant) other mothers experience much more difficulty? In the light of such comparison, they could be discredited as mothers, for being in need for more support or for having the postnatal depression experience. Thus, one direction for future research could be that of studying objectively the social support in the context of maternity, considering the different forms of social support, as well as postnatal depression intensity.

Specific themes

We also identified specific themes regarding postnatal depression experience. These themes are components of participants' individual experience and are important for our research, to create a thorough perspective on the phenomenon. They are also factors described in the literature about postnatal depression.

Intergenerational conflicts represent one of the causes of postnatal depression, according to the mothers participating in the transcultural study of Oates et al. (2004). In the Chinese culture, intergenerational conflicts are part of the etiology of this disorder's (Lee et al. 2004), the conflict between daughter-in-law and mother-in-law being the third important stressor as magnitude (Zheng & Lin, 1994).In our study, the conflicts with the extended family did not generate additional conflicts. On the contrary, the relationship with the husband remained a resilient factor for the mother. Future research should investigate the perceptions couples have regarding intergenerational conflicts and also investigate the specificity of conflicts in diverse cultural backgrounds.

The importance of cognitions for the etiopathogenesis of depression is well-known from literature. Irrational thoughts and obsessive thinking have been described before, in the cases of mothers with postnatal depression. These cognitions refer to women's perceived failure as mothers, to doubts about own normality and worries regarding the babies (Beck, 2002). Moreover, obsessive thinking regarding harming oneself or the baby have also been reported (Robertson et al., 2003). In our cases, the dysfunctional thinking consisted of worries regarding infants' health and wellbeing; own health; the possibility of harming the baby; mother's body image; and maternal abilities.

Practical recommendations

The screening of mothers after childbirth should receive special attention. As we have mentioned before, mothers in our sample had a covert experience in front of persons from their social context, including the medical personnel. The behavior we have observed in these mothers could be a compensatory strategy, aimed to cover the symptomatology for an outside observer. Additionally to screening via questionnaires, clinical interviewing and psychoeducation should be two solutions to be taken into consideration and further applied. We suggest this, since it is possible that mothers minimize their symptoms when completing the questionnaires, thus misleading the identification of PND by the clinician. It is also important to take into consideration ambivalence when approaching mothers with postnatal depression.

Theoretical implications

We suggest that other's understanding of maternal distressing experiences functions as a form of perceived emotional support and has to be further considered in the theoretical perspectives on postnatal depression, in

relationship to cultural norms of expressing and regulating emotions. On the other hand, our results regarding postnatal depression experience, dysfunctional cognitions, and instrumental social support sustain the operationalization of the phenomenon, as already described in the existing literature.

CONCLUSIONS

Through our phenomenological approach, we identified common, but also distinctive features of postnatal depression, relative to previous research. In summary, we saw that postnatal depression was a condition present both in urban (P3) and rural settings (P1 and P2). Mothers' experience was characterized by ambivalence in acknowledging the symptomatology, although they were familiar with the concept of postnatal depression. The daily routine of maternity offers structure, but it can become burdening due to the monotonous cyclicity of the activities. Moreover, maternal solicitations disconfirm the expectations for a facile phase after childbirth. Also, like in a downward spiral, there are to be added to this picture the worries, fears, dysfunctional thoughts and perceptions about social support. We can thus conclude that postnatal depression is a phenomenon characterized by common and also specific experiences across groups or contexts under study.

REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th Ed.). Washington, DC: Author.

Baban, A. (2002). *Metodologia cercetarii calitative* [Qualitative research methodology]. Cluj-Napoca, Romania: Editura Presa Universtitara Clujeana.

Beck, A.T., Steer, R.A., Brown, G.K. (1996). / David, D., Dobrean, A. (2012). *Inventarul de depresie Beck – ediția a doua (BDI-II)* [Beck Depression Inventory (2nd ed.)], Romanian Testing Services, Cluj-Napoca.

Beck, C.T. (1999). Postpartum depression: Stopping the thief that steals motherhood. *AWHONN Lifelines*, 3(4), 41-44. doi:10.1111/j.1552-6356.1999.tb01115.x

Beck, C.T. (2002). Postpartum depression: A Metasynthesis. *Qualitative Health Research*, 12(4), 453-472. doi:10.1177/104973202129120016

Bilszta, J., Ericksen, J., Buist, A., & Milgrom, J. (2010). Women's experience of postnatal depression – beliefs and attitudes as barriers to care. *Australian Journal of Advanced Nursing,* 27(3), 44 – 54.

Buultjens, M., & Liamputtong, P. (2007). When giving life starts to take the life out of you: Women's experiences of depression after childbirth. *Midwifery*, 23(1), 77-91.doi:10.1016/j.midw.2006.04.002

Chapman, E., & Smith, J. A. (2002). Interpretative Phenomenological Analysis and the New Genetics. *Journal of Health Psychology*, 7(2), 125-130. doi:10.1177/1359105302007002397

Cox, J.L., Holden, J.M., & Sagovsky, R. (1987). Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *The British Journal of Psychiatry*, 150(6), 782-786. doi:10.1192/bjp.150.6.782

Cooper, P.J., & Murray, L. (1995). Course and recurrence of postnatal depression. Evidence for the specificity of the diagnostic concept. *The British Journal of Psychiatry*, 166(2), 191-195. doi:10.1192/bjp.166.2.191

Cutrona, C.E. (1990). Stress and social support–in search of optimal matching. *Journal of Social and Clinical Psychology*, 9(1), 3-14. doi:10.1521/jscp.1990.9.1.3

Dennis, C - L., & Chung-Lee, L. (2006). Postpartum Depression Help-Seeking Barriers and Maternal Treatment Preferences: A Qualitative Systematic Review. *Birth*, 33(4), 323331. doi:10.1111/j.1523-536x.2006.00130.x

Dix, T., & Meunier, L.N. (2009). Depressive symptoms and parenting competence: An analysis of 13 regulatory processes. *Developmental Review, 29*(1), 45-68. doi:10.1016/j.dr.2008.11.002

Field, T. (2010). Postpartum depression effects on early interaction, parenting, and safetypractices: A review. *Infant Behavior & Development*, 33 (1), 1–6. doi:10.1016/j.infbeh.2009.10.005

Gaynes, B.N., Gavin, N., Meltzer-Brody, S., Lohr, K.N., Swinson, T., Gartlehner, G., Brody, S., & Miller, W.C. (2005). Perinatal Depression: Prevalence, Screening Accuracy, and Screening Outcomes. Evidence Report/Technology Assessment No. 119. (Prepared by the RTI- University of North Carolina Evidence-based Practice Center, under Contract No. 290-02-0016.) AHRQ Publication No. 05-E006-2. Rockville, MD: Agency for Healthcare Research and Quality.

Grace, S.L., Evindar, A., & Stewart, D.E. (2003). The effect of postpartum depression on child cognitive development and behavior: A review and critical analysis of the literature. *Archives of Women's Mental Health*, 6(4), 263-274. doi: 10.1007/ s00737-003-0024-6

Grace, S.L., &Sansom, S. (2003). The effect of postpartum depression on the mother-infant relationship and child growth and development. In Stewart, D.E., Robertson, E., Dennis, C.-L., Grace, S.L., & Wallington, T. (2003). *Postpartum depression: Literature review of risk factors and interventions* (pp. 197-251).

Hall, P. (2006). Mothers' experience of postnatal depression: an interpretative phenomenological analysis. *Community Practitioner*. 79 (8), 256 – 260.

Ji, S., Long, Q., Newport, D.J., Na, H., Knight, B., Zach, E.B. Stowe, Z.N. (2011). Validity of depression rating scales during pregnancy and the postpartum period: impact of trimester and parity. *Journal of Psychiatric Research*, 45(2), 213-219. doi:10.1016/j.jpsychires.2010.05.017

Kumar, R. (1994). Postnatal mental illness: a transcultural perspective. *Social Psychiatry and Psychiatric Epidemiology*, 29(6), 250-264. doi: 10.1007/BF00802048

Leahy-Warren, P., McCarthy, G., & Corcoran, P. (2011). First-time mothers: social support, maternal parental self-efficacy and postnatal depression. *Journal of Clinical Nursing*, 21(3-4), 388-397. doi:10.1111/j.1365-2702.2011.03701.x

Lee, D.T.S., Yip, A.S.K., Leung, T.Y.S., & Chung, T.K.H. (2004). Ethno epidemiology of postnatal depression. Prospective multivariate study of sociocultural risk factors in a Chinese population in Hong Kong. *The British Journal of Psychiatry*. 184 (1), 34-40. doi:10.1192/bjp.184.1.34

Lopez, K.A., & Willis, D.G. (2004). Descriptive Versus Interpretive Phenomenology: Their Contributions to Nursing Knowledge. *Qualitative Health Research,* 14(5), 726-735. doi:10.1177/1049732304263638

Lovejoy, M.C., Craczyk, P.A., O'Hare, E., & Neuman, G. (2000). Maternal depression and parenting behavior: a meta-analytic review. *Clinical Psychology Review*, 20(5): 561-592. doi:10.1016/S0272-7358(98)00100-7

Matijasevich, A., Munhoz, T.N., Tavares, B.F., Barbosa, A.P., Silva, D.M., Abitante, M.S. Santos, I.S. (2014). Validation of the Edinburgh Postnatal Depression Scale (EPDS) for screening of major depressive episode among adults from the general population. *BMC Psychiatry,* 14(1), 1-9. doi:10.1186/s12888-014-0284-x

Mauthner, N.S. (1998). 'It's a Woman's Cry for Help': A Relational Perspective on Postnatal Depression. *Feminism & Psychology*, 8(3), 325-355. doi:10.1177/0959353598083006

Nobel, R.E. (2005). Depression in women. *Metabolism – Clinical and Experimental* 54 (5), 49-52. doi: 10.1016/j.metabol.2005.01.014

Oates, M.R., Cox, J.L., Neema, S., Asten, P., Glangeaud – Freudenthal, N., Figueiredo, B. Yoshida, K., & the TCS-PND Group. (2004). Postnatal depression across countries and cultures: a qualitative study. *The British Journal of Psychiatry*. 184 (46), 10-16. doi:10.1192/bjp.184.46.s10

O'Hara, M.W., & McCabe, J.E. (2013). Postpartum Depression: current status and future directions. *Annual Review of Clinical Psychology*, 9(1), 379-407. doi:10.1146/ annurev-clinpsy-050212-185612

Patton, Q., & Cochran, M. (2002). A guide to using qualitative research methodology. *Medicines Sans Frontier* URL: *http://evaluation.msf.at/fileadmin/evaluation/ files/documents/resources_MSF/MSFuaitativeMethods.pdf*

Robertson, E., Celasun, N., and Stewart, D.E. (2003). Risk factors for postpartum depression. In Stewart, D.E., Robertson, E., Dennis, C.-L., Grace, S.L., & Wallington, T. (2003). *Postpartum depression: Literature review of risk factors and interventions* (pp. 9-70).

Robertson, E., Grace, S., Wallington, T., & Stewart, D.E. (2004). Antenatal risk factors for postpartum depression: a synthesis of recent literature. *General Hospital Psychiatry*, 26(4), 289-295. doi:10.1016/j.genhosppsych.2004.02.006

Sit, D., Rothschild, A.J., Wisner, K.L. (2006). A Review of Postpartum Psychosis. *Journal of Womens Health.* 15 (4), 352 – 368. doi:10.1089/jwh.2006.15.352

Smith, J.A., & Osborn, M. (2003). Interpretative phenomenological analysis. In Smith, J.A. (Ed.), *Qualitative psychology: a practical guide to research methods* (pp. 53-80). London: Sage.

Smith, J.A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*. 1 (1), 39-45. doi:10.1191/1478088704qp004oa

Stewart, D.E., Robertson, E., Dennis, C-L., Grace, S.L., & Wallington, T. (2003). Postpartum depression: Literature review of risk factors and interventions. Toronto Public Health.

Ugarriza, D.N. (2002). Postpartum Depressed Women's Explanation of Depression. *Journal of Nursing Scholarship,* 34:3, 227–233. doi:10.1111/j.1547-5069.2002.00227.x

Wisner, K.L., Parry, B.L., Piontek, C.M. (2002). Clinical Practice. Postpartum Depression. *The New England Journal of Medicine,* 347(3), 194-199. doi:10.1056/NEJMcp011542

Zheng, Y.P., & Lin, K.M. (1994). A nationwide study of stressful life events in Mainland China. *Psychosomatic Medicine*, 56(4), 296-305. doi:10.1097/00006842-199407000-00004