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MOTHERS AND HEALTH VISITORS

DEBORAH HENNESSY

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ABSTRACT

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MOTHERS AND HEALTH VISITORS

by Deborah Anne Hennessy

Health visitors have a responsibility for the preventive health care of all mothers and their young babies. Many mothers suffer a depressive episode during the postpartum year and the associated health visiting skills required testing, especially those of searching for health problems and giving support.

Mothers, their midwives, health visitors and family practitioners participated in an eighteen-month project, from the mothers' seventh antenatal month to their fifteenth postnatal month.

Psychiatric screening tests, questionnaires, health visiting records, and the observations and tape recordings of health visiting in homes were used for collecting information about the mothers' emotional health, and their health visiting care. Two hundred and thirty five mothers completed the eighteen-month study.

During this time 110 mothers (47%) became postnatally depressed. Sixty four of these mothers (27%) became depressed within the first six weeks postpartum. Health visitors thought 12 of the 110 depressed mothers (11%) were "at risk" of postnatal depression, and they only recognised 27 (25%) of the 110 depressed mothers.

These findings indicated that postnatal depression was a significant community problem and that the health visiting care could be improved.

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Portsmouth Health Authority supported my doing this research project by allowing it to be carried out in their district, and by altering my health visitor post for two and a half years, so that I could divide my time equally between research and clinical health visiting.

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For the sake of variety the terms postpartum, postnatal, post confinement and puerperal are used synonymously throughout the thesis, all referring to the events occurring in the months immediately following childbirth.

CHAPTER 1

INTRODUCTION

The present study investigated the health visiting care given to postnatal mothers. This is an important subject as the care of mothers and babies was included as the health visitor's normal responsibility in The National Health Service Act (1946). However health visitors do not care for children directly, instead they offer support and advice to their mothers, whereas the health visiting care of mothers has no intermediary person. To date there has been little research about the health visiting care of mothers, therefore, it was thought that an investigation of the subject could provide "first-hand" information about health visiting techniques and skills.

Additionally, although the establishment of the National Health Service has contributed to a physically healthy community, it has exposed many emotional health problems. Over the last twenty years health visiting literature and education has reflected an increasing interest in mental health care, particularly as problems such as infectious diseases and malnutrition have decreased. Yet, during this time there has been minimum research regarding health visitors and their work in the emotional health field. Nevertheless, health visitors customarily use many terms drawn from psychotherapeutic literature such as support, counselling, guidance, reassurance and anticipatory guidance; these terms describe health visiting activities with adults, or the parents of children, which have previously hardly been described. It was thought that research about health visiting care in the emotional health field might begin to examine the application of these techniques in health visiting.

It is important to see whether and in what ways health visiting has combined the medical approach to care - that is identifying and treating symptoms - with the social skills approach, which is designed to elicit co-operation and provide reassurance for clients. General nurses are trained against a background of illness; health visitors, who are all trained nurses, have to integrate their general nurse approach to symptoms and disease with their health visiting care, which uses the social skills of communication to promote health and prevent disease. The author believed that the health visiting care of postnatally depressed mothers required a combination of both medical and social skills approaches.

Postnatal depression is a disorder which can develop into a severe psychiatric illness, but its origins and definition are not very clear. However it appears to be an increasing problem (Cox, Connor & Kendell, 1982), and it is possible therefore that the consequences of prolonged maternal depression (Kumar, 1982), such as marital pathology (Dominian, 1976), poor mother-infant bonding (Margison, 1982) and behavioural disturbances in other children (Rutter, 1966) have also increased. Therefore postnatal depression was itself a subject worth investigating further.

The author was responsive to such influences because prior to the commencement of the present study she had trained as a health visitor in two countries: firstly in South Africa where the health visitor training is part of Community Health or Public Health Nurse training, secondly when arriving in Great Britain in 1976, the author retrained as a Health Visitor. The emphasis in South Africa was on meeting the different health needs of specific communities. She found that Health Visiting in the United Kingdom was still strongly influenced by the historical

system of home visiting new mothers and babies, as defined in the National Health Service Act, 1946. Health visitors had clearly become involved in the surveillance of children's development and potential child abuse, but their work in mental or emotional health was unclear. The author wondered if the emotional health problems that were emerging in Britain such as postnatal depression were being identified by health visitors, and whether adequate related health visiting care was being provided.

It appeared that for many postnatally depressed women the burden of their care fell almost entirely on the immediate family, and the health visitor (although in some cases the family medical practitioners might provide medical care). Therefore the health visiting care, in this context, raised the following questions. Are health visitors promoting maternal health and providing prophylaxis for postnatal depression? Do they recognise the vulnerable mothers? Are health visitors searching for the early signs of postnatal depression? What health visiting skills are required for the care, and support of these mothers ?

A preliminary study (Hennessy, 1978) suggested health visitors were not recognising all postnatally depressed mothers. Therefore a decision was taken to research the process of health visiting care given to mothers regarding their emotional health, in the year after childbirth. However this implied that the incidence of postnatal depression required measuring, before the associated health visiting skills could be scrutinised and described.

Therefore the framework of the present study was bounded on one side, by the incidence of postnatal depression in the sample, and on the other, by Health Visitors' knowledge, skills, techniques and opportunities for caring for these postnatally depressed women. Within

these limits the study was designed in the following way.

The history of puerperal mental illness is surveyed in Chapter 2 and particular attention is given to research about postnatal depression.

In Chapter 3 the literature concerning the needs of postnatally depressed mothers and their related care is scrutinised. The development of health visiting skills for working with emotional problems related to childbearing is examined.

The author's preliminary study is described in Chapter 4. The results of this study together with the information gathered from the literature in Chapters 2 and 3 assisted in formulating the objectives of the Main Study. These objectives are laid out in Chapter 4. This chapter also describes certain factors which influenced the study design, especially the characteristics of the locality and the population, and the reasons for choosing the two psychiatric screening tests.

The pilot studies and the method of the main study are described in detail in Chapter 5. This chapter ends with an outline of the sample response to the main study.

The incidence of postnatal depression and a description of the disorder in the sample in the present study are covered in Chapter 6.

Chapter 7 is short, but important, as it surveys the mothers' own opinions about how they coped with their depressed feelings postpartum.

The health visiting care of postnatally depressed mothers is scrutinised in Chapter 8.

A discussion of all the findings, together with recommendations for Health Visitors' education and the health visiting service are covered in Chapter 9.

The answers to the research questions were also important for the health visiting care of people with other emotional health problems; perhaps especially Bereavement or Marital Stress. Health visitors frequently come across the latter which is a problem of increasing magnitude (Dominian, 1983).

As with many studies in nursing the present study was complicated because it crossed the boundaries of other disciplines. It concerned mothers in an urban technological society which required information on the sociology of motherhood and community systems; the depressed mothers had specific health needs demanding an understanding of psychiatry and psychology, and the mothers' care necessitated knowledge about the development of the health services and health visiting education.

Finally the study had a quantitative and qualitative aspect which was described by Stephenson (1982) as a critical aspect for the development of research in health visiting.

CHAPTER 2

REVIEW OF POSTNATAL DEPRESSION RESEARCH

2.1. INTRODUCTION

The arrival of the baby is a major physical, social and emotional event in the life of both parents, but particularly for the mother and especially with her first baby.

Childbirth is a dramatic physiological process with many associated hormonal changes. The mother's status changes as may her relationship with her sexual partner. Many feelings are aroused by childbirth; there may be pride and pleasure, but also anxiety - will she be able to care for the new baby adequately, and how will she manage the new demands and responsibilities?

At the same time as these changes, or perhaps consequentially, mothers apparently become more susceptible to mental illness.
In this chapter past writings and research about puerperal mental illness are reviewed. Particular attention is given to postnatal depression information especially the incidence, the symptoms and the course of the problem.

The chapter ends with a discussion of the consequences of postnatal depression for the mothers, their babies and their families.

2.2. PUERPERAL MENTAL ILLNESS

Psychiatrists have been interested in the mental illness of childbearing women for many years, and for generations writers have described insanity after childbirth. Two thousand years ago, Hippocrates cited a case of a woman who gave birth to twins, experienced severe insomnia and restlessness in the sixth day of postpartum, became delirious on the 11th day, went into a coma and died on the 17th day.

Hippocrates thought about the cause of this postpartum illness and offered two hypotheses; the first related to lochial discharge and the second was associated with engorged breasts.

Another early description of Puerperal Psychosis was by Dr William Battiers in his Treatise on Madness published in 1758 (Tetlow, 1962). Hamilton (1962) surveyed the early literature on puerperal and lactational psychoses and made special mention of Marce's "Treatise" written and published in 1858 in Paris. At that time it was still believed that puerperal and lactational psychoses were specific illnesses only occurring at these times. This belief changed when in 1911 Bleuler maintained that schizophrenia presenting postpartum had no special features. This statement was endorsed by Kraepelin in 1913 who believed puerperal mania could only be provoked by childbirth when already latent.

The majority of the earlier studies considered mental illness in childbirth to be of organic aetiology. Tetlow (1962) reviewed this literature in the opening chapters of his thesis. However in the 1920's Zilboorg (1929 and 1931) investigated the psychogenic background of women presenting with the illness; he felt there was never only one cause and he also discussed the "depressive" reactions of both parents. He believed that a father could deny paternality, but the mother could not deny maternity, both for physiological reasons and because she has to care for the baby. Therefore, the mother's "maximum flight from reality" is a denial of being married and a rejection of the baby.

Bleuler and Kraepelin's denial of any special features of puerperal mental illness began a 50-year debate about whether puerperal mental illness was different from other forms of mental illness. This continued until Jaco (1960), Tetlow (1962) and Pugh and Macmahon (1962)

noted a higher incidence of mental illness in women than men during the reproductive years. They found these illnesses tended to have an onset shortly after delivery rather than at other times during pregnancy and the puerperium (Brockington, 1982). The publication of these papers revived the interest in puerperal mental illness. All early literature reflected general concern about women requiring admission to psychiatric hospital and with risks of suicide or infanticide. There were few prospective or community studies (Hamilton, 1962). Then two family practitioners Tod (1964) and Ryle (1961 and 1964) changed the pattern with community surveys. They found a 3% incidence of postpartum mental illness. This was much higher than the 0.1-0.2% recorded admission rate for postpartum psychoses into psychiatric hospitals (Paffenberger, 1982). Evidently the puerperal mental illness detected by the family practitioners was more neurotic in nature and less severe than the psychoses requiring hospital admission. Since Tod and Ryle's surveys several prospective and retrospective studies concerning puerperal depression have been completed by psychiatrists, family practitioners, nurses, sociologists and the general public, in hospitals and in the community. Recently considerable interest has also developed in a transitory problem, known as the "third day blues" (Pitt, 1973).

2.3. DEFINITIONS OF THREE SYNDROMES IN PUERPERAL MENTAL ILLNESS

The three syndromes within the broad spectrum of puerperal mental illness mentioned above are "the blues", postnatal depression and puerperal psychoses; these are defined in the following paragraphs.

The Puerperal Psychoses

The puerperal psychoses are severe mental illnesses developing in

the year after childbirth normally requiring help from the family practitioner, a psychiatrist and hospitalisation. The incidence is rare, with only one or two cases per 1000 births (Kaij and Nilson, 1972). This syndrome is well documented probably because of the severe implications for the baby and family relationships (Tetlow, 1962). The illness is usually schizophrenic or a very severe psychotic type of depression. The onset is sudden and dramatic often occurring within the first few days or weeks after childbirth (Dominian, 1976).

The Maternal Blues

The "maternal blues" are the least serious syndrome. The condition is characterised by fatigue, crying, anxiety over the baby, headaches, inability to sleep, confusion and sometimes hostility towards the husband. The incidence of this condition is extremely high and has been variously estimated from 50-80% of all pregnancies (Pitt, 1973 and Jacobsen, Kaij and Nilson, 1967). Many women describe tearfulness and misery lasting for a matter of hours, at most for one to three days. If forewarned the women are prepared and further action is generally unnecessary. Most people consider "blues" hormonal in origin (Yalom et al, 1968). However Kaij and Nilsson (1972) suggest there may also be a psychological function; which protects the mother from everyday trivialities, during the essential mother-child bonding time. Although "the blues" syndrome is generally free from psychiatric overtones a few women may show more subtle characteristics heralding serious problems.

Puerperal Depression

Puerperal depression may occur any time in the year after childbirth, but seldom within the first two weeks. In this syndrome the

mother feels tired, irritable and snappy with other members of the family. If this type of behaviour was apparent before the baby's birth it becomes worse. The mother usually has a decrease in sexual desire and she frequently feels inadequate. The problem may not be explicit and varies greatly in intensity, often requiring assistance from members of the primary health care team. The mother may seek help indirectly by asking for assistance with her baby, rather than herself. Although only the most severe require psychiatric help and hospitalisation, the illness may have serious long-term effects on the mother's relationships with her baby and husband.

It has been suggested that interest in the less severe puerperal mental illnesses has emerged since infections have been successfully treated. However although parapartum neurotic disturbances such as postnatal depression may be less severe than puerperal psychoses they are nevertheless distressing. Furthermore they are relatively widespread. Pitt's (1965) survey indicated a 10% incidence of puerperal neurotic disturbances which contrasted with the incidence of psychoses of only 0.1%-0.2%. Thus, further investigations were stimulated.

2.4. PRE-PARTUM MENTAL ILLNESS

Slowly and progressively the interest moved from the postpartum to the pre-partum, and even pre-conception phases of a mother's childbearing life. The pre-partum mental illness studies began only recently. The start was delayed possibly because Paffenberger's study in the 1950's suggested that pregnancy postponed psychiatric illnesses until after childbirth (Paffenberger, 1982). He investigated all female admissions of childbearing age to psychiatric hospitals in Ohio during

1957-1958. The computed results showed that mental illness rates in pregnancy (7.1 per 10,000 woman years) were substantially lower than among women not in childbearing status (35.1 per 10,000 woman years). However rates during the six months postpartum (40.3 per 10,000 woman years) were slightly higher as a group than for non-childbearing women and markedly higher in the first weeks following delivery. Paffenberger's study concerned women who were very ill and admitted to psychiatric hospitals. His findings suggested an amelioration or postponement of psychotic illnesses by pregnancy.

The comments of other authorities may also have reduced the interest in pre-partum illnesses; for example Dominian suggested that depressive reactions in pregnancy were rare (Dominion, 1976)."

Kendell et al (1976) claimed that the incidence of postpartum mental illness was large and could not be regarded as a postponement of pre-partum illness which contrasted with Paffenberger's statement.

Nevertheless there were studies of pregnancy neuroses and these provided base line information for the postpartum studies. In 1982, Kumar produced a fascinating review of the current thought and research regarding the psychological and physiological effects of pregnancy on the mother's health. Kumar included studies of depression and anxiety states in pregnancy. He outlines the difficulties of pregnancy studies; these were unstandardised measurements, highly selected or self-selected samples and poorly defined depression diagnosing criteria. Kumar noted the biased picture possibly presented by hospital and psychiatrist based antenatal studies, because they may not include the less severe psychiatric disturbances. Another difficulty of pregnancy studies was finding suitable control and comparison groups. A few investigators tried to find a pre-pregnancy baseline in a retrospective fashion

(Breen, 1975 and Kumar, 1982).

Three studies, Tod (1964), Dalton (1971) and Meares, Grimwade and Wood (1976) related antenatal anxiety to depression postpartum. After examining the evidence provided in these three studies Kumar (1982) concluded that it was insufficient to link antenatal anxiety to postpartum depression. A number of other studies (Pitt, 1968, Sherefsky and Yarrow, 1973, Breen, 1975, Oakley, 1980, Uddenberg and Nilsson, 1975, Brown, Bhrolcain and Harris, 1978, Kumar and Robson, 1978 (a and b), Cox, 1979, and Zajicek and Wolkind, 1981) were also examined in detail by Kumar leading to the following conclusions. The incidence of depression appeared to be raised during pregnancy; the association between antenatal anxiety and postnatal depression is still to be confirmed; all studies to date suffered from the limitation that their samples were derived from women who attended antenatal clinics and excluded non-attenders (who may well be those most psychologically disturbed).

2.5. POSTPARTUM NEUROTIC DEPRESSION

In 1968 Pitt reported his finding of a 10.8% neurotic depression incidence rate in postpartum women, within six weeks of childbirth. This finding has been confirmed by some and even higher incidence has been noted by others (Breen, 1975, Oakley, 1979 and Marks, 1980).

Pitt's study was an important milestone in postnatal depression research because he recorded the incidence of depression (i.e. new cases) and not prevalence (i.e. the number of cases of a disease in a population at a given time). Additionally he developed a screening questionnaire to detect potential postnatal depressives. Although he found he could not predict postnatal depression before childbirth, Pitt,

as a psychiatrist, took care to list the criteria he used for defining the presence of postnatal depression (Pitt, 1968). Interestingly this study was initiated because a health visitor told Pitt about the quantity of maternal depression she found in her work. Fifteen years of research followed Pitt's well documented study. The ensuing publications and literature will be discussed in the following pages.

Intriguingly there is little information to date about the severity of the depression, nor about treatment and care, or the effects of counselling and chemotherapy. Similarly little scientific information has emerged about the long-term effects of postnatal depression on the mother and her relationships.

Despite the health visitor's remarks referred to above and the health visiting involvement with women, few articles concerning postnatal depression appeared in the health visiting press until Snaith and Brandon's articles in 1983, although a number of writers mention health visitors' involvement with puerperal women (Oakley, 1979 and Clulow, 1982).

2.6. INCIDENCE OF POSTNATAL DEPRESSION

Perhaps the incidence of postnatal depression is the most confused and debated aspect of the relevant research. Before Pitt's study, Tod (1964) mentioned a maternal depression incidence of 2.9%. The figure came from a sample of 700 women whom he saw on several occasions in the postnatal year. Kumar (1982) was wary of this result because it is so out of phase with the estimates of Pitt and later researchers and suggested Tod only included very seriously depressed women. Pitt however estimated an incidence of 10.8% in a sample of 300 women studied only up to six weeks after childbirth.

Nilsson and Almgren (1970) did not define their clinical criteria for puerperal depression but reported an incidence of clear mental disturbance in 19% (the actual number was not given) of their sample of 192 women. Apparently two thirds of these women became unwell within two months after childbirth (Kumar, 1982).

An incidence of 23% in a sample of 112 mothers was reported by Blair et al in the Journal of the Royal College of General Practitioners (Blair et al 1970. Dalton found that 7.5% of 189 women became puerperally depressed; all these women required outpatient psychiatric help or drug therapy (Dalton, 1971). Another study in 1971, Breen's, found 33% of 51 women showed some degree of maladjustment and 21.5% of 51 mothers showed serious maladjustment two to three months after childbirth. The study was particularly relevant to the present study because Breen used Pitt's Anxiety Test to measure this maladjustment (Pitt's Anxiety Test was used in the present study).

Wolkind and Zajicek (1978) noted an incidence of 10% in their sample of 139 mothers. Using her own questionnaire, Oakley estimated a depression incidence of 15% in her sample of 50 women. In her book Dignity of Labour, Cartwright estimated an incidence of nerves and depression in 43-48% of postnatal women (Cartwright, 1980). In this study differences were noted according to social class, incidence rising from 34% in social class 1 to 51% in social class 5. The social class difference appears similar to the difference in prevalence of psychiatric illness in women (Brown and Harris, 1975). In their study The Social Origins of Depression Brown and Harris (1978) made a very important statement about pregnancy or birth and the onset of depression because they found that their patients had a rate of pregnancy and birth events that was twice that of normal women. The authors believed that

When the event of a pregnancy and birth is meaningfully related with an ongoing difficulty such as a bad marriage, then the event and the difficulty can act together to increase the risk of a depression.

> ".....there is no evidence that child birth and pregnancy as such are linked to depression. The high rate of depression associated with child birth was entirely due to those rated as severe*: only pregnancy and child birth with a severe ongoing problem played an aetiological role. .....the result clearly suggests that it is the meaning of the events that is usually crucial: pregnancy and birth, like other crises can bring home to a woman the disappointment and hopelessness of her position - aspirations are made more distant or she becomes even more dependent on an uncertain relationship."(Brown and Harris, 1978)

The mothers rated as severe were those who had other crises in their lives such as inadequate housing and bad marriages.

Marks in one of the few published health visiting studies on maternal depression suggested an incidence of about 48% in a sample of 40 women (Marks, 1980). Ball (1982) was concerned with health visitors and postnatal depression, but her paper dealt with her method rather than her findings.

Paykel et al (1980) studied 120 women attending postnatal clinics around six weeks post-confinement finding 17% (21 women) with postnatal depression. Playfair and Gowers (1981) found 10% of (62 out of 618) mothers suffered with postnatal depression 8-20 weeks after childbirth. Kumar and Robson (1978, a and b, 1982) mention an incidence of about 12% and Cox, Connor and Kendell (1982) found a postnatal depression incidence of 29% (30 out of 103 mothers) at 3-5 months postpartum (13 mothers were severely depressed and 17 mildly depressed). All these studies used different measurements of depression and different sampling methods.

Some studies limited themselves to first-born children (primaparae) or to groups drawn from certain social classes, and any attempt to generalise from their results has to be cautious. However the lowest

estimate of the incidence of postnatal depression mentioned above was 12%. The principal difficulty in interpreting even these results was the lack of precision in defining the limits of puerperal depression, in terms of the time elapsed since the birth. No-one has defined when the period which can justly be termed POSTNATAL depression begins or ends. In the light of present studies there is no cut-off point where it can be said a depression that develops in the year after childbirth is not postnatal depression. For example it is unknown whether a depression that develops eight months after childbirth is connected with the parturition process or something else in the mother's environment.

An important point is the variation of the onset which may be well after normal contact with obstetricians and general practitioners. Kumar and Robson (1978) found an incidence of 10% (12 out of 119) in the first 3 postnatal months, a further 2.5% (3 out of 116 mothers) in the following three months and another 2.5% (3 out of 118 mothers) between six months to a year after childbirth; that is a total of 15%. Mothers were not continuously screened for postnatal depression during the postnatal year in any of the studies mentioned above. Another unclear phenomenon is the duration of postnatal depression.

2.7. THE DURATION OF THE DEPRESSION

In Pitt's study all his patients were disabled for at least 2 weeks and the illness usually lasted for several weeks. Several writers have noted that postnatal depression may persist for some time after childbirth. This will affect a mother's relationship with her baby and family and may create a need for more adequate support systems and the involvement of health care workers.

Snaith (1982) affirms that for many mothers postnatal depression

resolves itself spontaneously within a few weeks. Kumar and Robson (1978) found that depression did not persist in a clinically significant form for the whole postnatal year in many of their mothers. Pitt (1968) also followed up 28 of the women who had been depressed six weeks after childbirth, by a postal enquiry when their babies were a year old and found that 40% of these mothers were still depressed at the end of the year (Pitt, 1968). Similar results were reported by Rees and Lutkins (1971), Dalton (1980) and Tentori and High (1980). While Dominian (1974) described women depressed for months and even years after having a baby.

2.8. WHO SUFFERS WITH POSTNATAL DEPRESSION OR ANXIETY?

In both postnatal and general neurotic depression there are certain similarities, namely the symptoms and the effects discussed later in this chapter. This possibly also applies to the origins of depression, which include events in society and the individual's life. Brown and Harris (1978) stressed that it was the meaningfulness of the event or experience that was crucial and as in other crises pregnancy and birth can bring home to a woman the hopelessness of her position, especially when there also other ongoing problems in the mother's life.

Dewsbury's thoughts (1979) about today's society and neurotic depression may well apply to postnatal depression. He showed that neurotic depression appeared to be increasing.

The first National Morbidity Survey (all patients attending approximately a hundred general practitioners) showed an incidence of neurotic depression in 1955/1956 of only 14 per 10,000. By 1979/1981 the incidence was 314 per 10,000, a 22-fold increase in fifteen years. During the same period other varieties of mental and physical illness

had increased far less (Dewsbury, 1979). Dewsbury believed this phenomenon was secondary to social change. He noted the increasing understanding by professionals of the "at risk" factors of depression, which had developed from Brown and Harris' work (Brown and Harris, 1978 and the editorial in the Lancet, 1978). He also commented on the advances in medical treatment which alleviated the symptoms, while social security and rehousing reduced hardship. However, despite these, Dewsbury discerned the existence of an increasing contemporary inner personal insecurity. He thought there might be an explanation in the stressful nature of life in modern society, claiming that everyone was encouraged to be individualistic, rather than becoming a member of a mutually supportive and helpful community. Simmel discussed this as far back as 1908. He described the changes in urban life as "the forces of life" which had "grown into the crowns and roots of the whole of Historical Life" (Thompson, 1971 p93). For example urban man receives his essential supplies of food and water from authorities (shops and city councils) and urban man does not get to know these people and cannot gain psychosocial support from them. This is particularly so as many of urban man's dealings with authorities would be by telephone or letter. If perchance these dealings are face to face the people in authority often change with succeeding visits, for example the official in the Department of Health and Social Security Office, therefore the individual's isolation and loneliness increase.

Cassell (1974) thought an individual required "feedback" from the community network system about whether his/her actions had a desirable or expected effect. Small nuclear families, rapid social change, and social disorganisation, reduce the bonds in a community network system and make feedback difficult. This can become a pathogenic element

increasing susceptibility to disease (Cassell, 1974). In 1974 Caplan proposed a theory that a small supportive social network of people surrounding a person may reduce the harmful effects of the absence or confusion of "feedback" provided by the general population. This lack of a widely shared appreciative communicative system in the community was formulated by Sir Geoffrey Vickers as "the crucial problem of our times" (Caplan, 1974).

Caplan (1974) and Henderson S. (1977) claim the social network is essential to provide social bonds and "support". All these factors affecting neurotic depression may well be associated with postnatal depression; having a baby frequently compounds the problems. For example a young woman may move into a new locality with her husband. The young woman may work until late in her pregnancy, and then be confined to home after childbirth with no-one available for discussing her mothering abilities and difficulties. A mother's support systems include her nuclear and extended family, the most important relationships being with her own mother and her sexual partner (Beattie, 1978 and 1979, and Rapaport and Rapaport, 1977). The larger community supplies additional support, some of which may be influenced directly or indirectly by the health care workers especially the health visitor (Children's Committee, 1980). Henderson S. (1977) thought that the more trustworthy the base of support was, the more the individual might take it for granted, and could overlook its importance.

It is unclear whether, apart from childbirth, there are any special features which separate postnatal depression from depressive episodes at other times. However many researchers have searched for specific indicators for suspecting the development of postnatal depression in certain mothers (that is identifying those "at risk" of developing

postnatal depression). These indicators will be discussed in the following three broad categories: the mother's personal, social and biological history.

2.9. MOTHER'S PERSONAL HISTORY

In the psychoanalytical literature postpartum depression is described as a significant and not uncommon condition occurring at a crucial point in the life cycle, with repercussions and implications of pathogenic vulnerability for both mother and infant (Blum, 1978). Generally psychoanalytic studies suggest maternal puerperal depression is associated with women who had disturbed relationships in their childhood (Kumar, 1982). Similarly Breen (1975) believes postpartum depression has no circumscribed entity, instead it is a symptom of underlying pre-existent disturbance. Marris (1974) described postnatal depression within a background of the loss and change model. In the model, change (birth of the baby preceded by pregnancy) appears as a fulfilment or a loss to different people. For example one mother may feel she has gained positively by having a baby and another may feel she has lost her freedom, whereas other mothers may sometimes feel they have gained and at other times lost something by having a baby. However both fulfilment and loss have common features requiring a re-establishment of continuity.

This means finding an interpretation and meaning for oneself and the world, and an acceptance of the ambivalence of the mother's task. The outcome depends on the individual's ability to face the conflict and find one's way through.

Frommer and O'Shea (1973) and Kumar and Robson (Kumar 1982) argued that the transitional period to motherhood was often found to be a time

for regression and the re-opening of past developmental conflicts. Particularly mentioned were the correlations of postnatal depression in mothers and their reported separations from their fathers for a period before the age of 11 years, with concurrent difficulties with their mothers. Possibly certain psycho-social factors correlating with postnatal depression were comparable with the vulnerability factors for neurotic depression in women with young children described by Brown and Harris (1978). These vulnerability factors were the caring for three children under fourteen years of age, the mother's absence of close ties (especially with her partner), unemployment, and the women's separation from their own mothers before the age of 11 years. However, Brown and Harris (1978), themselves did not find a specific link between childbearing and depression. Kumar (1982) claimed that this failure possibly resulted from restrictive research methods and incomplete comparisons rather than implying that such links did not exist.

It has been noted that contemplating a termination of the pregnancy may lead subsequently to postnatal depression (Kumar, 1982). Neither Pitt (1968) nor Kumar (1982) found correlations between a previous psychiatric history and postnatal depression. However, both Playfairs and Gowers (1981) and Paykel et al (1980) reported a positive correlation between postnatal depression and previously treated psychiatric illness, or a previous postnatal depression. Few research workers have found links with postnatal depression and measured characteristics of personality (Kumar, 1982).

Pitt (1968), Blair et al (1970) and Dalton (1980) noted that age, marital status, previous marriages and number of children appeared to be connected clinically with postnatal depression, but they found little statistical evidence. Bereavement anniversary dates are known to have

some influence on neurotic depression in the general population (Raphael, 1978), nevertheless very little has been reported about associations of postnatal depression with bereavements. Two types of bereavement that have been found to affect the mothers' emotional health in the postnatal period are stillbirths (Clarke and Williams, 1979) and sick children (Harrison, 1979).

2.10. FATHERS

Pitt (1968), Kumar and Robson (1978, a), Paykel et al (1980) and Playfair and Gowers (1981) all noted correlations between marital disharmony and postnatal depression. However few studies discuss aspects of fathering or the father's influence on the mother's moods after childbirth. Some years ago White (1957) described how mental illnesses associated with childbearing and the confused terminology ritualised a woman's pregnancy. Terms such as puerperal insanity, gestational psychosis, confusional insanity, are attributed to mothers. Fathers have no similar scientific or medical recognition. Significantly, medical explanations of childbearing mental illness pivot on the mother's attitudes or hormones, with the father's responses rarely mentioned (Richman and Goldthorp, 1978). In Parsonian terms fatherhood takes a culturally subordinate role, men are expected to play instrumental-adoptive roles, whereas women are allocated expressive-integrative ones (Parsons, 1951).

Fathers have not appeared in the psychological literature of children's normal development until rather recently. Probably the delay was because the majority of child psychiatrists after Freud were female (Howells, 1970). Josselyn (1956) suggested that if fatherliness or even fathers' interest in baby affairs was described it could have attributed

an effeminate element to men. In 1972 Pawson and Morris characterised man's natal career as a secondary relationship, and less significant to a man than a woman's relationship with her children; in addition men experience no hormonal or remarkable physical changes to assist in identifying with their baby. In one of the few studies investigating husbands' personalities and the effect on the childbearing mother Pilowski (1972) found an interesting association. He showed that mothers whose husbands were more socially active with numerous interests outside the home, were more likely to have severe emotional complications. Marks (1980) noted a correlation between fathers' absence at the birth and the mothers' subsequent depressions. Hopkins (1980) made an attempt to find out whether husbands were a factor in mothers' psychiatric illness following childbirth. His findings suggested that it was possible that husbands who are insecure as a result of life events might not be able to meet their wives' emotional demands.

2.11. BIRTH PROCESS

Pitt (1968) found little evidence to support correlations between highly technological births and postnatal depression. However Oakley (1979 and 1980) mentions the birth process together with social vulnerability as indicative factors. Additionally Cartwright (1980) found a 43% incidence of nerves and depression in mothers with a spontaneous labour, and 48% in mothers with an induced labour. None of these differences, though suggestive, was sufficiently clear cut to be statistically significant. Kitzinger (1978) and Graham (1980) both found associations with the birth process and the place of birth and maternal depression.

2.12. BIOLOGICAL ASSOCIATIONS

Brockington et al (1982) and Hamilton (1982) reviewed the biological influences in the genesis of puerperal psychotic disorders. Dalton (1980) described biological sources for postnatal depression. She calls postnatal depression "atypical" as did Pitt (1968), but for different reasons. Pitt did so because the symptoms were different from neurotic depression, whereas Dalton did so because it responded to drugs which would not have been effective with a neurotic depression. (Kumar noted there were differences in Dalton's descriptions of postnatal depression and her treatment.) It is interesting that Pitt (1968) and Beattie (1978) found correlations with dysmenorrhoea (prior to the pregnancy) and postnatal depression. However, Beattie (1978) thought dysmenorrhoea may be an individual reaction to being a woman rather than a hormonal condition. When defining dysmenorrhoea as a condition requiring medication, Nott (1982) found no correlation with postnatal depression.

2.13. POSTNATAL DEPRESSION SYMPTOMS

Jacobsen, Kaij and Nilson (1965) discussed two types of depression found in 25% of an unselected sample of women up to one year after childbirth, as follows.

1. The first type showed common symptoms of fatigue, irritability, tension, anxiety and sometimes a vomiting baby (the latter has been shown by Carne, 1966, to have an association with a depressed mother).
2. The second manifested a milder atypical psychological depression.

In these cases there was a prominence of neurotic symptoms such as anxiety and phobias overshadowing the depression. Also the women felt worse at the end of the day rather than early in the day and suffered from early rather than late insomnia. This depression was usually treated by the general practitioner. Jacobsen suggested that a sizeable proportion of cases of atypical depression in women in the community arose and continued after childbirth (Jacobsen et al, 1965).

In Pitt's study, all the women were disabled by the depression for at least two weeks. The disability usually took the form of difficulty in coping with the baby's demands, husband, other children and housework.

Many researchers have provided lists describing postnatal depression symptoms. These symptoms include crying, discontent, loss of appetite, loss of interest, occasional ruminations, sadness, self-accusation, self-doubt and tiredness, insomnia, irritability, anxiety (often related to the baby), depression, delusions, neurotic symptoms, restlessness, labile moods, decreased interest in sex, panic attacks, lack of interest in the baby or other children, and difficulties with relationships (White et al, 1957; Seager, 1960; Hamilton, 1962; Rutter, 1966; Pitt, 1968; Blair et al, 1970; Kaij and Nilsson, 1972; Breen, 1975; Dominian, 1976 and Arieti, 1980).

Jacobsen, Kaij and Nilson (1965) found that 5% of mothers suffering from puerperal depressive illness had six symptoms or more. Playfair and Gowers (1981) found three months after the birth of a child that 24% of a sample of mothers experienced three symptoms of depression, whilst 10% experienced six symptoms. Postnatal depression was diagnosed by Pitt (1968) in those mothers who had felt depressed for a period of at least a week after childbirth, provided this was accompanied by at least

two other symptoms. Pitt called postnatal depression "atypical" because only two of his patients showed the classical picture of a depressive illness, with suicidal ideas and worsening of depression in the early morning and early morning waking. Further reasons were the prominence of neurotic symptoms and the generally milder nature of the disturbance (Pitt, 1968).

Similarly Snaith (1982) suggested the diagnosis of a severe depressive disorder of mood in the postpartum period may be obscured by using the term "postnatal depression". He thought this because the presentation is so different from general neurotic depression. The similarities between the two include the core symptoms of depression, fatigue, insomnia, loss of libido and the inability to experience pleasure. However the core symptoms of postnatal depression are usually overshadowed by other symptoms particularly anxiety and irritability. In traditional psychiatry anxiety states are distinguished from depressive states. Snaith believed a young postnatal mother showing acute anxiety may be thought to have a flaw in her personality or inadequate mothering skills, whereas the mother probably has postnatal depression. Snaith (1982) maintains that irritability, a symptom commonly associated with postnatal depression is seldom included as a symptom in general depression.

Breen (1975) and Snaith (1982) think the term postnatal depression should be changed to avoid the conflict around the name and definition. Blair et al (1970) thought that a mother would feel unwell even if she had only one unpleasant symptom of depression; moreover this would affect the whole family. However it is difficult to devise objective criteria in identifying depression, whether post-natal or not, as has been noted by Wing, Cooper and Sartorius (1974) and Shapiro (1981). The

problem is that of judging whether particular forms of behaviour are symptoms of depression. For example, tears found distressing by one person may be normal to another.

Breen (1975) emphasised the importance of noting the symptoms described by the mothers themselves, for these are more important to her than definitions of her symptoms made by some other person. Furthermore Breen believed a definition based on physical parameters was inapproprate; she said it ignored how the mother felt. This was particularly so as the meaning of the health in a mother may be her ability to adapt to a changing environment.

Ritchie (1970) developed a list of symptoms, both subjectively and objectively described. This list could be used by a nurse visiting a mother and a new baby, to predict postnatal depression developing within three months after parturition. The subjective factors include physical disturbances (such as reduced appetite and loss of weight), emotional disturbances (such as loss of libido, sadness and crying spells) and cognitive disturbances (such as self-criticism and inability to cope with the infant's needs). The objective factors include facets of appearance (such as posture, speech, weight loss), and activity (such as slowing down or agitation).

2.14. THE CONSEQUENCES OF POSTNATAL DEPRESSION

The course of disease in the women studied by Pitt usually lasted several weeks and only a few women received direct treatment. Some received care indirectly by expressing their distress as a concern over the baby, especially feeding, to the general practitioner or the health visitor during a home visit or in the child health clinic. Up to date, little information has been published regarding the possible long term

consequences to the mothers themselves: especially the consequences of their diminished self confidence or reduced coping abilities, whilst suffering postnatal depression.

However psychiatrists are familiar with women appearing as outpatients, who have been unwell since the birth of their last child, for a period of weeks, months or more than a year. Apparently they see several such women for every case ill enough to be admitted to hospital (Pitt, 1968).

2.15. THE BABY

The association between infanticide and maternal mental illness has been recognised by society and formalised in the Infanticide Act (1938). The act treats the killing of a child under a year by its mother as manslaughter instead of murder.

Nevertheless reports conflict about the effects of a mother's postnatal depression on her baby. Zilboorg (1931) attributed postpartum psychiatric illness to the mother's maternal rejection of the baby and her flight from reality. In an unselected sample of 404 obstetric admissions, Jacobsen et al (1965) determined the frequency of psychiatric symptoms in the postnatal period, and they rated 28 mothers (7%) as having a fear of hurting their baby. Seager (1960) when describing the changes of mother-child relationships after postpartum mental illness, noted that ill mothers wished harm to their babies, yet they had normal relationships later. The reverse was apparent for others, with six mothers having a normal relationship while unwell and an abnormal relationship when feeling better. In 1966 Rutter noted many children attending child guidance clinics had parents with a psychiatric disorder, but not necessarily postnatal depression.

There are rather few specific studies noting the effects of maternal depression on mother-baby relationships. Renvoise (1977) mentioned NSPCC statistics claiming more children were abused in the months after their mother had a new baby. Lynch and Roberts (1977) noted early bonding difficulties associated with later child abuse. There may be an association with difficulties in bonding and subsequent postnatal depression; Margison (1982) found depressed mothers frequently reported lack of feelings, associated abnormal ideas, irritability or anger towards the baby. Commonly, a highly anxious mother presented with mild depressive fears and intense feelings of not coping with the baby. These mothers and babies often moved into a vicious cycle of failed feeding, increased crying, with further feelings of anxiety and panic for the baby. Although the situation eventually resolves and both settle down, it is unknown if there are longer or lasting damaging consequences.

Another condition "failure to thrive", a syndrome where a baby does not grow, gain weight or develop normally can be seen as a physical consequence of emotional deprivation and may develop after or during a postnatal depression episode (Margison, 1982). Emery (1983) of the Sheffield Study believes that, occasionally, maternal depression may be a factor contributing to the sudden infant death syndrome. Frommer and O'Shea (1973 a) noted that sleep and feeding problems were likely in depressed mothers' babies. It is uncertain whether these problems developed because of the mothers' depression, or possibly because the depression led to more reporting of the problems. Harvey (1978) suggested the important issue is the recognition of the mothers' possible depression when these symptoms are presented.

Further consequences of puerperal mental illness have connections

with more of the mothers' relationships. For example, older children in the family may be bewildered by the change in their mother's temperament. They may react to the event with eventual behaviour disturbances of their own, developing negative attitudes towards their new sibling (Snaith, 1982). Home Office and Department of Health and Social Security (1978) and Cox, Connor and Kendell (1982) comment upon the association of marital disturbance and postnatally depressed women. Finally Dominian in a Royal Society of Medicine paper claimed that if this one problem of postnatal depression could be prevented it would make a substantial difference to marital pathology statistics (Dominian, 1976).

The considerable volume of research about postnatal depression noted in this chapter illustrated many aspects of the problem still requiring clarification, which included the incidence, the duration, the possibility of predictive factors, the associated problems and the consequences. The researchers used methods based on qualitative measurements for diagnosing postnatal depression; these are of course open to a range of interpretation and it was therefore not surprising that they produced widely differing information on the incidence and prevalence of puerperal depression. It was also questionable whether a women's distress and dysfunction were identified by the health professionals if these symptoms were not severe enough for a psychiatrist's diagnosis of postnatal depression. The reliance on pychiatric diagnoses may have oversimplified the problem and not taken full account of the mothers' own experiences of their distress and dysfunction. The author found it extraordinary that the health needs, or the health visiting care required by these women had received little attention from researchers; as health visiting is directed towards the

child and maternal health. This raised the question of whether previous research had provided adequate information about postnatal depression regarding how to predict or detect the problem. Another question was "were health visitors using the information?". These questions led to the author's research investigating aspects of postnatally depressed mothers.

CHAPTER 3

THE HEALTH VISITING CARE OF POSTNATALLY DEPRESSED WOMEN

3.1. INTRODUCTION

Literature concerning postnatal depression incidence, onset, duration, associated psychosocial factors and possible consequences was reviewed in Chapter 2. The concept underlying the relationship of the health care needed by postnatally depressed women and the provision of such care is explored in this chapter, notwithstanding a paucity of relevant published information and research. However the review includes especially an appraisal of the historical and theoretical influences on health visitors' progress in caring for emotional problems in mothers. An attempt is made to identify the essential health visiting skills, however this is rather complicated as to date it appears that each health visitor defines her objectives and priorities by differing criteria, thus using different skills (Robinson, 1982, page 85); these are usually from one of two bases, the clinical and medical or the relationship and social science base.

3.2. A DEFINITION AND FRAMEWORK OF HEALTH NEEDS.

Before beginning the discussion the term "needs" requires defining. Johnson and Davis (1975) described needs as "certain tangible and intangible items which the human being must have in satisfactory amounts in order to maintain physical and psychological homeostasis". The physical and psychological balance can be called health. When a person's needs are over-filled or under-filled, the balance is disturbed. The disturbance creates a patient problem, which may be illness or dysfunctioning.

Unfortunately needs have different meanings; these are dependent upon the persons defining the need. A framework provided by Bradshaw (1972) clarified four distinct sources of need definitions.

The first was "normative need" which is usually defined by the experts or professionals in given situations. Difficulties arise from normative needs because one person's definitions may not necessarily correspond with others. Conflicting standards may be laid down by different experts. The standards may develop from value orientations of the different experts, and will change with the development of knowledge and societal differences.

"Felt need" is the second concept and is similar to want; a felt need measures a person's needs unsatisfactorily and is limited by individual perceptions. A person may feel a need if there is a helpful service available, or, instead to avoid confessing an inadequacy, they may not feel a need .

The third definition is the "expressed need" whichis a "felt need" turned into action. It is a need defined by persons demanding a service.

The fourth interpretation is the "comparative need"; this describes needs in one area receiving a service, with similar needs in another area not receiving a service.

Ivan Illich maintains that externally attributed needs, or normative needs as defined by the professionals, may have disabling instead of enhancing effects. However he also believes that professionals cannot define a need unless people already experience, as a deficiency, a lack of that which the professional imputes as a need.

3.3. THE NEEDS OF POSTNATALLY DEPRESSED WOMEN.

Using Bradshaw's four needs, the needs of women with postnatal depression could be described as follows. "Normative needs" would include the women thought by the professionals to have postnatal depression. The difficulties of describing the normative needs of postnatal depression have been illustrated in Chapter 2, namely the varying definitions, together with many different research estimates of incidence (Kumar, 1982) and subjectivity when assessing symptoms (Snaith, 1982). For example a nurse or doctor may believe a woman with certain symptoms is postnatally depressed and requires treatment, whereas the woman may believe she herself is not depressed but that her baby is ill. This scenario could also be reversed where the mother feels depressed but the nurse and doctor think it is a baby problem.

An estimate of the degree of "felt need" can be obtained by asking the mothers if they feel depressed and what health care they would like (Breen, 1975 and Oakley, 1980). This is important because mothers feeling even mildly depressed, may find the experience as devastating as the women who become very ill and require hospitalisation, this is especially likely if the mildly depressed women have previously usually been cheerful and carefree.

Possibly, Women's Movement Groups are expressing needs of the community by demanding the health care professionals' understanding of puerperal mental illness. Women's groups such as the National Childbirth Trust, the Postnatal Depressive Illness Society and the Depressives Association could be included amongst the groups expressing the community needs. In this regard Welburn, who describes herself as a writer and mother, makes strong demands for health visitors' care of

mothers. In her book Postnatal Depression (1980) she says:

> "Health visitors are in the best position to detect and watch over depressed mothers and some are very concerned about the problem..... Many.... however, seem to be mainly concerned with the physical aspects of baby care and provided the baby is not actually neglected assume all is well ..... this deprives mothers of their most obvious source of help".

Perhaps too, needs are being expressed by the increasing research in the subject, especially as the research has been stimulated by information from both professionals and clients. Various other avenues express the needs of puerperally depressed women. For example, the literature concerning associations of postnatal depression with vomiting babies (Carne, 1966 and Marginson, 1982), non-accidental injury (Renvoise, 1977) or marital pathology (Dominian, 1974; Stotesbury, 1978 and Cox, Connor and Kendell, 1982) could be expressing puerperal womens' needs.

Measuring the needs of puerperally depressed mothers receiving care against the needs of those not receiving care may exemplify the comparative needs. The Short Committee (Social Services Committee, 1980) described comparative needs among childbearing women. They particularly exposed

> "the need for the reversal in some areas of a degree of inhumanity and a lack of understanding of women's needs; and the removal of anxiety and dread from the minds of expectant, parturient and puerperal patients" (Short, 1980).

In the last paragraphs four different interpretations of postnatal depression as a health need were described. Whereas Johnson and Davis' definition of needs in an earlier paragraph described the items (needs) required for the reduction of the health problem, and a return to homeostasis, the provision of these needs or items to maintain homeostasis could be called "CARE". In most instances, the identification of specific needs (items), and appropriate care of

postnatally depressed women only began recently. In 1982 these were clearly identified by Snaith and are summarised as follows. The women and their husbands require understanding, support and an explanation of the disorder; the symptoms and the usual course should be explained to the mother and her family. Snaith maintained medication should be avoided, as much postnatal depression clears up spontaneously within a few weeks. However when medication was required it should be active and continued until all traces of the disorder have been eliminated. Furthermore, Snaith explained that mothers frequently do not volunteer information about their symptoms (felt needs). Therefore routine and careful enquiry should be part of postnatal care and should occur, at least, at one month and three months after birth. As the above mentioned needs were described by a professional they are "normative needs".

Medical recognition of the illness has been noted to be therapeutic, as many women and their families blame their symptoms on physical disorders or personal inadequacy, excluding the likelihood of a recoverable emotional disorder (Brandon, 1983). Brandon emphasised the use of relationship skills, such as providing reassurance and the opportunity for mothers to talk about their feelings. The mother also requires help emotionally and practically from her family and the professional carers. The help should develop the mother's self confidence and competence. Practical help such as babysitting or adequate laundry facilities may be as beneficial as psychotherapy. The effectiveness of methods of care (such as Brandon's and Snaith's) for postnatally depressed women have not been evaluated. However the community appear to be requesting a similar therapeutic approach (expressing needs) as shown in Welburn's book Postnatal Depression

(1980), in a chapter called "Talk and Tablets", page 192:

> "many women have no desire to probe their psyche, they just want a helping hand for a few weeks, someone to share their problems, maybe take their toddler out occasionally or do a bit of shopping until they get on their feet. This kind of befriending is what the extended family and close community always provided, since they are breaking down, organisations have to be formed to do the job".

The care described above has two elements. Firstly a clinical base requiring knowledge of symptoms, their course and appropriate treatment. Secondly the relationship base requiring contact between the mothers and carers and psychotherapeutic skills to identify the problem initially. These skills are also used to listen to the mothers, reassure them and to encourage further supportive care from the mothers' community.

3.4. PROVIDING CARE FOR POSTNATALLY DEPRESSED WOMEN.

In 1973 the Regional Officer for the European Region of the World Health Organisation compiled a document called The Development of Comprehensive Health Services in the Community. The limited resources in trained staff was a point raised in the document and thought to be the most serious hindrance to further development of these services. There was a reference to the two models of health care already raised in this chapter, as follows. The document emphasised that the life saving role of doctors and nurses tended towards the medical model of care , whereas in the community other models of care might be more appropriate. All countries were obliged to seek ways and means of ensuring the better use of staff already available, and the redeployment of resources.

Since 1976 the Director General of the World Health Organisation has encouraged health teams to care for the population by focussing on consumer determined needs (expressed needs). They also urged the teams to involve consumers in defining the health care programmes to meet

these needs (WHO, 1976). Therefore the next section in this literature review considers those involved in providing health care for postnatally depressed women and their families.

WHO PROVIDES THE CARE?

Interestingly most articles and research about postnatal depression have been completed by psychiatrists and psychologists, for example Pitt (1968) and Kumar and Robson (1982). However these health care professionals normally only meet the most severely depressed mothers and only after referral from the family practitioner or health visitor. Cox, Connor and Kendell (1982) noted that only few postnatally depressd women were actually seen by psychiatrists, compared with the incidence recognised by research .

Community psychiatric nurses may have a caring role for these mothers, but only when these mothers have been referred to their care. There is little literature describing this care.

A more critical look at the pattern of maternal health care shows that the obstetricians see far more of the mothers before they have their babies than afterwards. Similarly midwifery care normally ceases 10 days postpartum (at latest 28 days). The general practitioner may see the mother at antenatal clinics, at the postnatal clinic (6 weeks postpartum), and when the mother, or a member of her family is unwell. Health visitors are therefore exposed as possibly the prime carers for mothers, especially as they are encouraged to meet mothers and children routinely, and usually a minimum of 5 times in the first year after childbirth (Court, 1976; Henderson J., 1977 and Portsmouth and South East Hampshire Health District, 1978). There are many areas in the United Kingdom where routine home visiting by health visitors is

exceptional. Nevertheless postnatal mothers are usually visited at home, at least once, after the health visitor has been advised of the baby's birth notification:

> "At this first visit the health visitor will observe the physical, mental and social conditions of the family while giving advice on the physical and emotional needs of the baby and control of its environment. She may also explain the relevant services available in the vicinity, drawing attention to the value of attendance at child health clinics and to the importance of immunisation and, if appropriate, she may discuss family planning. At the same time, she will be assessing any social needs, remaining constantly alert to the possibility of puerperal depression, child abuse or inadequate parentcraft.....On the basis of the first visit, information about the birth and any relevant facts available, the health visitor will assess how soon she should visit again" (Health Visitor's Association, 1980).

This detailed description is well summarised by the Council for the Education and Training of Health Visitors' definition of the function of health visitors. In the definition five main aspects of health visiting work are outlined, as follows.

> 1. The prevention of mental, physical and emotional ill health and its consequences;
> 2. Early detection of ill health and the surveillance of high risk groups;
> 3. Recognition and identification of need and mobilisation of resources where necessary;
> 4. Health teaching;
> 5. Provision of care; this will include support during periods of stress, and advice and guidance in cases of illness as well as in the care and management of children. The health visitor is not, however, actively engaged in technical procedures (CETHV, 1967)

Another definiton providing a useful summary of health visiting work is Owen's (1977):

> "Health visiting is concerned with the principles of healthy living, the prevention and detection of illhealth and the building up of families' and individual personal resources so that they can better cope with the crises of life".

Health visitors are trained nurses with obstetric experience and have taken a year's practical and academic training during which the psychological aspects of childbearing are stressed. The health visitor

is not required to have any experience of, or training in, psychiatry. The last point is a subject of ongoing debate.

It would appear from the above discussion that health visitors might be in the category of staff "who are available but requiring better deployment" referred to in the document already mentioned, The Development of Comprehensive Health Services in the Community (WHO, 1973). Additionally the health visitor's role in identifying patient needs (CETHV's 1967 point 3 above) certainly meets the directive, in the 1976 WHO document, of focussing on consumer determined needs . These bare statements about the health visitors and their care of mothers is expanded in the following pages. Special attention is given to the influences on health visiting by Government legislation, official policies, research findings and new techniques of caring.

3.5. THE HISTORICAL DEVELOPMENT OF THE HEALTH VISITING CARE OF MOTHERS AND PEOPLE WITH EMOTIONAL HEALTH PROBLEMS

In the United Kingdom health visitors have had a responsibility for providing preventive health care for mothers and children for a long time. Historical events and their associations with health visiting developments have been well documented by others. Reviews can be found in Clark (1973, Chapter 1), Owen (1977, Chapter 1), Robinson (1982, Chapter 1), White (1982) and RCN (1983, Chapter 2). Robinson's review is particularly comprehensive covering more than 100 years in 3 stages, as follows, before 1909, 1909 - 1946, and after the National Health Service. Wilkie (1979) described events affecting the training and education of health visitors and particularly the Council for the Education and Training of Health Visitors in the years 1962 - 1975 (

therefore including the 1974 NHS Reorganisation). A subsequent writer Batley discusses the years 1975 -1979 (Batley, 1983). The Nurses, Midwives and Health Visitors Act 1979 led to the formation of National Boards and a United Kingdom Central Council in 1983, replacing all nursing councils and boards, including the Council for Education and Training of Health Visitors.

An aspect of health visiting care not clearly documented is its extension into the emotional health field. Until the National Health Service Act 1946 health visiting was undoubtedly located in the field of physical and environmental health. Two important events in the early years of this century had focussed health visitors' attention on mothers and children, the Notification of Births Acts 1907 and 1915 and the Maternity and Child Welfare Act of 1918.

After the introduction of the National Health Service health visiting care was extended to the whole family. At the same time other workers emerged also providing a family service, such as social workers and family medical practitioners; few people had had a genuinely family medical service before this time. However, with the advent of the NHS all families were able to register with a medical practitioner, and receive free medical care for health problems. In the decades after World War 2 there were certain changes in society and the family structure, particularly the emergence of the mobile nuclear family. This meant "other people" replaced the old extended family in providing even "knowledge from experience" and "support in childrearing" (White, 1982).

The NHS Act 1946 greatly affected health visiting. The Act (Section 24, paragraph 111) gave Local Health Authorities responsibility

> "for providing health visiting services for the purpose of giving advice as to the care of young children, persons suffering from

illness and expectant or nursing mothers, and as to the measures necessary to prevent the spread of infection".

Much material in the following paragraphs is derived from White (1982). She explains historical developments in the years between the beginning of NHS and 1961, which led to health visitors' work with mothers in the emotional health field. The mental health services were amalgamated into the National Health Service in 1948. It was thought at this time that the new care and after care developments in mental health would extend the role of the health visitor. White (1982) discussed the departmental circulars, at this time, that discussed the intentions of Section 24, para 111 (quoted above), mentioning that "illness" included mental illness .....

In 1948, the Children Act removed the responsibility for certain aspects of child health care from the Health Departments and transferred these to Children's Social Work Departments. This could have meant more opportunities for implementing the work in the NHS Act (White, 1982). The new health service and the registration of the population with general practitioners brought another big change affecting health visitors. Slowly mothers, especially pregnant women, drew away from the Local Health Authority Clinics and ante-natal clinics run by midwives and health visitors, as they could obtain individual care for minor health problems freely from general medical practitioners. The medical practitioners were becoming more interested in maternal care and were responsible for signing the maternity benefits claims forms.

Subsequently health visitors began to be part of primary health care teams attached to general practitioners. At first this was an uneasy association. Health visitors were the only members of the team whose work was primarily concerned with persons in the community "at risk", but not presenting an immediately identifiable medical problem. This

meant that health visitors were the team members specifically considering future health and not working in the curative field. Ambiguous roles and role expectations developed which may have reduced effective health visiting care (Dawtrey, 1976). These difficulties are not totally resolved in the 1980's, although Harding's committee (1981) were satisfied with Primary Health Care Teams and their effectiveness, and recommended their continuance.

After the war, living conditions were greatly improved and together with pharmocological developments, contributed to changes in disease patterns. Infectious diseases were almost controlled. However these changes were compounded by other problems. People lived longer, but the new housing led to the separation of the generations, and the young and old were deprived of emotional support from each other (White, 1982). The separation led to the elderly having to manage their ageing years alone, and the younger generation bringing up their families, without the available experience and guidance of the previous generations (Wilmot and Young, 1957). This separation included the one third of the elderly population who had no children but who had previously been important members of the extended family (Titmus , 1963). These maiden aunts and uncles provided important additional support to young families, such as babysitting while the tired mothers got some rest.

By the 1950's, after the Butler Education Act 1944, people's expectations were raised; clients' needs were more related to mental health. White suggests these developments were perceived as social problems which health visitors were not thought to be trained to manage. Unresolved social problems often manifested as mental illness and health visitors were not trained to handle these either in the early 1960's, nor possibly in the 1980's. In the 1960's health visitors had

little understanding of mental illness or of inter-personal relationships, and they were already very busy with heavy case loads of mothers and young children. Moreover the research into puerperal depressive illnesses was only just beginning (Pitt, 1968).

In the 1950's a working party chaired by Sir W Jameson undertook an Enquiry into Health Visiting (Jameson, 1956). The terms of reference of the Working Party were:

> " to advise on the proper field of work, the recruitment and training of Health Visitors in the National Health Service"

To date this is the only government enquiry specifically about health visitors' work and the committee's discussions about health visiting in the mental health field will be considered in the following paragraphs.

They reported in 1956 and recommended that future health visitors should continue with Maternity and Child Welfare and should also become the general family visitor. The committee discussed health visitors' training requirements and described the existing courses as too short, too crammed, too theoretical, and too little concerned with modern views on psychological and family relationships. The committee suggested that the object of health visitor training should be to provide the student with essential technical information, to teach the principles of health visiting and demonstrate that in all her work she should be concerned with family welfare in a wide sense.

The training should enable health visitors to recognise cases where personal relationships are important, so that she could work more effectively or bring cases to the notice of other agencies. Apparently most witnesses reporting to the Jameson Committee emphasised health visitors' work in the complex subject of "mental hygiene". The committee believed this was correct but they also believed that care

should be taken to avoid too great a stress on a highly technical matter which they felt called for an arduous training beyond the scope of the general duties of the health visitor.

It was thought that health visitors should have a careful training in interviewing skills with an introduction to the psychological aspects and a framework of appropriate advice. They should learn "sympathetic listening" to provide an outlet for clients hidden and irrational anxieties. It was also thought that health visitor's part in mental illness would be essentially supportive, though she may need to play a more active role in the absence of specialist help. The committee regarded this as a specialised aspect of "mental hygiene" calling for more guided observation and demonstration than for more technical knowledge.

They indicated that not more than a general introduction to psychological theory was needed, with the exception in the case of mothers and children, when there should be a concentration on the development of children to adolescence and especially in the relationship of parents and children. This was to improve the value of the health visitor's own work, and to enable him or her to give maximum help to the expert medical and non-medical staff, concerned with the promotion of satisfactory mental development and in the re-adjustment of any departure from the normal. (Jameson, 1956, pp. 132-134, paras. 252, 353 and 357).

It would appear that the report was encouraging health visitors to become more involved with their clients and to take on tasks in mental care and after care especially with mothers and children. Although health visitors were thinking their training syllabus should be changed, White (1982) noted that the Royal College of Nursing maintained that

psychiatric social workers should be responsible for the mentally ill. Very interestingly, White claims that the Royal College of Nursing Education Committee up to the 1960's would not set up courses in medico-social work, or case work techniques, for health visitors.

White suggested that many of these historical events encouraged health visitors to be family generalists rather than remaining as maternal and child health specialists. It would seem that this has continued over the next two decades.

Society's developing understanding of the association between the mental and social aspects of health were reflected when the function of the health visitor was redefined by the Council for Education and Training for Health Visitors in 1963. As for the first time, the definition of the health visitor's work included emotional ill-health among its five main aspects. (The definition was mentioned earlier in the chapter). Prior to this time emotional ill-health had rarely been discussed in health visiting and was certainly a new factor with regard to education and training. In 1977 the CETHV stated that Dr J G Howells in a paper about the function and training of health visitors, had pointed out to the CETHV, in 1963, that careful examination of the health visitor's role of advisor and educator on a variety of health and welfare problems, showed that many so-called welfare problems were emotional in nature (CETHV, 1977, pp 14).

Certain other events in nursing and health care also influenced the health visiting care of mothers and those with emotional problems. For example a few years before Dr Howells' paper, in 1955, Virginia Henderson's Principles of Nursing was published. Two passages have been so influential in community health care that they are reproduced below. Henderson defined the function of the nurse as follows:_

> "The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge, and to do this in such a way as to help him gain independence as rapidly as possible. This aspect of her work, this part of her function she initiates and controls; of this she is master. In addition she helps the patient to carry out the therapeutic plan as initiated by the physician. She also, as a member of a medical team, helps other members as they in turn help her to plan and carry out the total programme whether it be for the improvement of health, or the recovery from illness or support in death." (Harmer, B and Henderson, V, 1955, pp 4-5)

Henderson (1963) discussed this definition in her introduction to Basic Principles of Nursing Care:

> "Basic nursing care as pictured here applies not only to any patient but to any setting. The principle of deriving nursing care from human needs might be a guide in promoting health as well as in giving a morbidity service. We are therefore discussing preventive and curative nursing. The same principles apply when the nurse advises a healthy expectant mother and when she takes care of a person prostrated by fever."

This definition is particularly interesting because of the concept of health care promotion related to human needs.

Nearly simultaneously the World Health Organisation Expert Committee on Community Health Nursing incorporated "family nursing" under the heading community nursing, emphasising that all individuals cared for by nurses are in fact members of families and communities:

> "Family health nursing is based on the concept of the family as a unit and is directed towards meeting the health needs and concerns of the family by encouraging it to use its own resources both human and material and by indicating the best way to use available health services." (WHO, 1974).

While these concepts of Henderson and WHO were developing in Community Nursing, various ideas were being tested in the preventive aspects of community psychiatry. Caplan was particularly influential, firstly in defining 3 levels of prevention: the first level in promoting health, the second in searching for problems and the third in providing supportive care; secondly Caplan emphasised the concepts of community

support systems as pre-requisites for community mental health; thirdly, he suggested that carers should intervene actively during times of individual or family emotional stress. Caplan called the latter "Crisis Counselling" (Caplan, 1974).

3.6. HEALTH VISITOR RESPONSIBILITIES

By the end of the 1960's the range of caring responsibilities undertaken by the health visitor had grown, and the state of practice was summarised in Appendix 8 of the Mayston report (Department of Health, 1969). The Mayston Committee was appointed by the Department of Health in Autumn 1968 under the chairmanship of E L Mayston. The terms of reference were:

> "to consider the extent to which the principles of the Salmon Report on the Senior Nursing Staff Structure in the Hospital Service are applicable to the Local Authority Nursing Services and what changes in the structure of Senior Posts and what changes in the definition of posts may be required".

Naturally it considered the contribution of health visitors and its membership included Miss E E Himsworth, Miss I John, Miss A M Lamb and Mrs D M Riddell who all had important knowledge of the subject. The committee's list of health visiting responsibilities had, therefore, considerable authority and was widely accepted at the time. These were summarised :

> i. Health Education and advice to all families or individuals she visits in the home, the doctor's surgery or the clinic or health centre.
>
> ii. A regard for the medical, psychological and social needs of the whole family.
>
> iii. A readiness to take account of psychological factors in every case with which she deals. At all times the health visitor should be aware of her role in the promotion of mental health and the prevention of mental illness.

iv. Comprehensive counselling services to families in need, and the seeking of appropriate help from the agencies.

The recommendations above, all consider aspects of emotional health, although they are but few of the 60 items described in the report. Whether health visitors actually fulfilled these responsibilities was not shown in this report.

3.7. RESEARCH ABOUT HEALTH VISITORS

A number of researchers have attempted to record the work done by health visitors. Clark (1981) reviewed small and large research studies about health visiting in her book entitled What do health visitors do". The book was designed as a resource for those making policy decisions affecting the health visiting service, and for those wishing to undertake further research in this field.

Twenty five of the thirty-seven studies investigated the proportion of time spent by respondents' on various activities. In most of these studies the findings were based on the respondents own self-recorded estimates. Clark noted that moral overtones, the health visitors' desire for prestige, desire to give the expected answer and desire to please may have influenced the recordings. Notwithstanding these problems Clark drew together all the findings on allocation of time (in Chapter 3) , and in Chapter 4 she discussed the available information that concerned the health visitors' clients. Clark noted that most of the studies were simple descriptions; two exceptions were Walworth-Bell (1978) and Wiseman (1979). Both these studies attempted to match health visiting activity with the "needs" of a given population. The overall picture of health visiting research was summarised in Chapter 14 together with suggestions for future research.

Hicks (1976) gave considerable attention to a number of these studies when discussing health visitors in his book Primary Care. He presented tables from different researches to provide further information about health visitors and their clients and their work. The topics and persons that health visitors considered important can be interpreted from these tables. In Table 179, (Hicks, 1976, pp. 264), the number of cases seen by health visitors in 1972 and 1973 were derived from the Annual Report of DHSS, 1973. In 1973 health visitors contacted 2,684,595 children under 5 years, approximately 702,000 were born in 1973. However the health visitors only recorded having seen 436,000 adults, that is persons aged between 17 and 64 years. From these figures it could be suggested that health visitors work with few mothers, in fact at the most only half the mothers of new babies (436,000 adults for 702,000 new babies). Probably the statistics imply that a mother was seen with every child, and obviously babies are unlikely to be unaccompanied. The emphasis was on children whereas health visitors were supposedly responsible for mothers and children.

Hicks also reproduced Marris' Table called "Topics covered by Health Visitors". This was an analysis of 89,000 topics covered in 401,000 minutes. Maris noted 4.0% of the topics discussed were emotional or mental problems, and they were covered in 5.0% of the total health visiting time. It seems that very little time was spent on the mothers' or anyone else's emotional health. Marital problems were possibly a related topic and these, including family planning, made up the total of 4.0% of the emotional health topics. The only other topic area which could have been related to the mother was called "Other Health Problems", this made up 3.0% of the topics and took 4.0% of the total health visiting time. Summarising these points shows that a maximum of

12.0% of the health visiting topics, in 15.0% of the total health visiting time, might possibly have been concerned with mothers and their emotional health care.

In Clark (1972) (also scrutinised by Hicks) there was a Table called "Topics and Households". In this table the incidence of topics recorded in home visits to different types of household (number of occurrences recorded, expressed as percentage of number of visits recorded in each group) were as follows. In 452 visits to households containing a young child 24.0% included a topic related to the mother's physical health and 16.0% included a topic associated with the mother's mental health. Marris and Clark's surveys were completed in different health districts, Marris' 1969 survey was in the Greater London Council and Clark's survey, also in 1969, was in Berkshire.
(All figures in the above paragraphs have been rounded up to whole numbers by the author).

Interestingly, despite these earlier reports covering health visitors' work there are still few in-depth studies either of specific areas of health visiting work, or the skills and techniques required for the work. Certainly there has been minimal discussion of health visiting in the emotional health field. Perhaps the slow development of this area of research was due to priority being given by other concerns. Health visiting studies more concerned with the techniques of care are discussed later in the chapter, in the section on health visiting skills.

3.8. HEALTH VISITORS EDUCATION ABOUT MENTAL AND EMOTIONAL HEALTH

Since the 1960's health visitors' training and education gradually came to include aspects of mental and emotional health. Howells, a

consultant psychiatrist, had considerable influence on this aspect of health visiting from the mid 1960's. He wrote 2 chapters in a health visitor text book called Principles of Health Visiting, edited by Cunningham; the first Chapter was called "The Psychiatric Aspects of the Family", and the second "Special Aspects of Psychiatry". The information in these chapters was concentrated and clear, providing certain guidelines about the investigations health visitors should make for the emotionally ill, especially the interview. This was described in some detail and he advised health visitors to explore with individuals their emotional difficulties and to see if obvious stresses could be identified. Therafter the health visitors were advised to explain the present situation in the light of the causes and to help the individuals or the families overcome any damage to their health. It would seem that health visitors were being given very clear positive guidance about their work with emotional illness.

The interesting point is that Howells, together with Walker, a consultant child psychiatrist (also a contributor to the above book), were among the first psychiatrists discussing health visitors' work in the detection, alleviation and treatment of emotional illness in primary health care.

Although the WHO Committee (1974) encouraged the development of community mental health services, Hicks (1976) showed great caution; commenting on the contributions of the psychiatrists above, he thought this type of work was particularly difficult and required disciplined training and close supervision over a period of years. He believed neither general practitioners nor health visitors were equipped to deal with and catch the signals heralding emotional illness. Hicks considered that psychotherapeutic treatment methods were untested, and quoted

liberally from the work of Balint (1957) and Medawar (1967) to support his statements.

Balint had spent many years running training courses for family practitioners and tried to demonstrate how psychotherapy could be developed as a useful tool in general practice. He described and suggested certain difficulties in the relationship type of care. For example the psychiatric examination of a patient is not nearly as scientific as the physical examination, and the psychotherapist and the patient have to work hard to identify the patient's problem; this could be a painful experience for both. Medawar claimed in 1967 that there was no convincing evidence that psycho-analytic treatment as such was efficacious, and unless strenuous efforts were made to seek it, the entire scheme of treatment would degenerate into a therapeutic past time, for an age of leisure.

Hicks maintained that in all his readings he did not detect a point being reached that would allow methods being put forward for general application in Psychotherapy. Perhaps Hicks had not considered the work of Carl Rogers who started testing the effectiveness of psychotherapy in the 1930's (Rogers, 1972). Hicks did confess that his approach to the review of mental health in primary care was superficial because he had no training in psychology or psychiatry. However he did note that Wolff in a paper on "The Place of Psychotherapy in the District Psychiatric Sevices", asserted that there was enough evidence of the benefits of psychotherapy, without the need for further research.

Nevertheless Hicks suggested that the medical model for mental illness was inadequate and perhaps treatment, at least in psychosomatic illness should be along the lines of the educational model; this was similar to the statements from the World Health Organisation (1973)

which were noted earlier in this chapter. Caplan's theories in preventive psychiatry in the community (mentioned earlier in this chapter) had been published by 1976 when Hick's book was published; they followed the educational model particularly in the suggested "crisis counselling" techniques. The work of both Rogers (in non-directive counselling) and Caplan's theories (and similar theorists) have been adopted in relationship-centred work by social workers, counsellors and other caring professionals. These techniques have been introduced in various ways into health visitors' training in their psychiatry, psychology and sociology lectures. Refresher courses and in-service training in counselling have been undertaken by many qualified health visitors, for example Family Planning Association Courses (1981), Bourne's course for health visitors at the Tavistock Institute (1981) and many other courses.

The syllabus for preparation for The Examination for Health Visitors inthe United Kingdom (CETHV, 1981) includes many points that could direct health visitors to the identification of emotional health problems and the provision of appropriate health visiting care:

Section 1 Development of the Individual

The....., emotional, ...growth of the individual and factors affecting development.....

Section 11 The Individual in the Group

This section.....involves an analysis of the forces that generate social change and influence individual behaviour.....

Section V Principles and Practice of Health Visiting

.....

Aims and Objectives of the Health Visiting Service.

.....

Identification of need , primary and secondary prevention.
Care and guidance in cases of breakdown in physical and/ or mental health.
Mobilisation of services to meet health and social needs.

Theories and methods of health visiting practice.
The art of looking and listening.
The development and use of understanding and empathy.
The identification and analysis of problems.

The syllabus is interpreted in different ways by the various colleges and universities that educate health visitors. In the Southampton University Course which leads to the Certificate in Health Visiting the following lectures were included in 1983 - 1984.

Section 1 Development of the Individual

Human Behaviour	
Developmental Psychology	40 lectures
Child Study and Human Behaviour	40 lectures
Child development	12 lectures

(compare the number of lectures in the above categories with those below)

Maternal Health and the Middle Years	4 lectures
Aspects of ageing	6 lectures

Section 11 The Individual in the Group

Social Skills	20 lectures

Section V Principles and Practice of Health Visiting

Skills and Methods	24 lectures and 40 seminars.

The above outline of lectures shows little direct reference to mothers or their emotional health; there were only four lectures specifically concerned with maternal health and these also included "the Middle Years"! These lectures were given by a number of different specialist lecturers and the subject of postnatal depression was raised. Nevertheless these lectures were only a small fraction of the total course preparing health visitors to be generalist family visitors, but the emphasis on child health noted above suggests that health visitors

are not really being educated to be Generalist (as decribed by White, 1982) Family visitors (as noted by Jameson, 1956), but rather Specialist Child Health Visitors.

Howells continued teaching health visitors for many years, and also wrote useful articles such as "Emotion and the Health Visitor" appearing in a 1977 Health Visitor Journal. Simultaneously in some areas health visitors were being taught and influenced by other psychiatrists: in 1978 Spicer described 20 years experience of teaching psychotherapeutic skills to health visitors (Spicer, 1978). During this period an explosion in counselling activities was taking place in Great Britain with the creation of the Standing Conference on Counselling followed by the development of the British Association of Counselling in about 1977. This and the case-work techniques being developed by social workers certainly filtered in to health visiting, although health visitors have never been trained in case work.

The discussion in the above paragraphs shows that the health visitors' academic and practical training has included some information about emotional illness, for more than two decades.

In 1979 the Royal Commission on the National Health Service commented that the burden of handling postnatally depressed women fell almost entirely on the immediate family and the health visitor. They felt that the problem needed to be identified accurately and that health personnel needed the skills to handle the problem for the best advantage for the patient. The commission also recommended the expansion of health education (a health visiting skill), with some resources spent on developing the most effective methods, and monitoring and validating existing and new techniques (Merrison, 1979).

3.9. TECHNIQUES AND SKILLS

Relationship-centred and communication skills and techniques have not been clearly defined in health visiting, and there is great difficulty finding out information about how they are used. Hayward (1977) noted that little was known about how the skills such as "supporting" or "teaching" were being used by health visitors and community nurses in their work. Perhaps researchers in health visiting have had investigation difficulties, because they, like Hicks (1976), have had little training in psychology and psychiatry. This has probably been compounded by the extreme difficulty of measuring the values of the problem-orientated methods or the relationship-centred approaches. These are usually inextricably intertwined and cannot easily be separated for measurement. It may also be too difficult because every health visitor uses different proportions of the two methods depending on her own personality, experience, training, interest, nursing management and the priorities of her primary health care team. Added to this, health visitors are introduced to the confusion of varying psychological theories and psychotherapeutic methods, during their very full academic year of training.

The Council for the Education and Training of Health Visitors (CETHV) started a discussion of skills in their book An Investigation into the Principles of Health Visiting (CETHV, 1977). This began a debate followed by two further books The Investigation Debate (CETHV, 1980) and Principles in Practice (CETHV, 1982). The last mentioned has 9 chapters, including two concerned with health visiting skills. The first was a chapter about social skill training for health visitor students and the second concerned intervention skills.

There is little information concerning the practicality of health

visiting skills. Indeed what are health visiting skills? In Time to Learn, a published report developed from a workshop (chaired by Fitton, 1980), skills were described as "activities" which when done repeatedly are done better, or quicker, or more efficiently, or more appropriately, or with more positive discrimination than when attempted by the untrained.

In 1981 the Council for the Education and Training of Health Visitors (CETHV, 1981a) drew up a list called "Major Professional Skills". The list outlines seven major groups of skills covering three A4 pages. At the same time the CETHV claimed that the training and nursing background of health visitors enabled them to use communication, observation, assessment, teaching, counselling, evaluation, research and management skills (CETHV, 1981 b).

3.10. SPECIFIC SKILLS

A few specific health visiting skills of particular relevance to the author's research will be discussed in this section.

One of the skills mentioned by the CETHV was teaching. Health visitors' involvement in emotional health promotion (health teaching, or the primary health care prevention of emotional illness) has been mentioned frequently in the literature. Janis (1969) described the value of anticipatory guidance, because a person puts up with suffering and deprivation, if they think about it beforehand, rather than enjoying expectations of personal invulnerability. Both Breen (1975), and Pitt (1968), discussed the value of preparing women during pregnancy for the postpartum stresses.

Many research projects both large and small have tried to evaluate

mothercraft classes and the adequacy of their preparation for motherhood, Boswell (1979), Oakley (1979), Graham (1980) and Rees (1981). Some of these Court (1976) and Barber (1977) suggested that health visitors should intervene positively, and start health education or anticipatory guidance with mothers before childbirth.

Another skill or combination of skills frequently attributed to health visiting is known as the health search. This has been defined by the CETHV as one of the principles of health visiting, and described as follows.

> "The health visitors' prime aim is to search for health needs and help individuals, families and groups to provide for them" (CETHV, 1977, page 28)
>
> "Time is needed to search, identify, recognise and assess the specific health needs of the family. Time is needed for both observation and for the establishment of relationships through which needs can be recognised ..... obviously in practice some or all the principles of health visiting are being applied simultaneously" (CETHV, 1977, page 29).

The health search obviously requires a knowledge of and the ability to recognise symptoms this is a skill probably required by all nursesand could be said to be based on the clinical model.

Certain constraints limit the search for health needs including ethical considerations and the ability to provide the care required once the needs have been identified.

Ritchie (1977) in an interesting and useful paper attempted to guide the visiting nurse in her search for emotional illness in the puerperium. In the paper Ritchie developed a list of symptoms both subjectively expressed (needs) and objectively described (normative needs), that a nurse visiting a mother and a new baby could use to predict postnatal depression one to three months after parturition. "The search" could enable health visitors to perceive those mothers who may develop postnatal depression and the mothers' needs.

The perception of needs in health and social care has been investigated by Mayer and Timms (1970), Byrne and Long (1976), Balint (1967), Orr (1978), Luker (1982) and Robinson (1982). All these writers asked whether the caring professionals were sufficiently aware of the client's perceived health care needs? This last point about needs and the differences in perception between client and professional was raised at the beginning of this chapter. However it is crucial to the present study and Weber dealt with the concept clearly by stating that the sociologist (? health visitor), if he hopes to explain what is going on, must attempt to see the world through the eyes of those (? client) he is studying if an adequate account is to be had (Timasheff, 1966).

The health visitor also needs to understand the client's community support system. When health visitors search for the needs of the mothers, they gain information about the social networks available for supporting the mothers. An increasing number of authors have described support systems available for mothers after childbirth; many of these are organised or encouraged by health visitors, Rubin (1975), Hennessy, Holgate and Marr (1978), Becker (1980), Children's Committee (1980), Robertson (1980), Hiskin (1981), Clulow (1982), Hennessy with Moulds, Crack and Murray (1983) and Hennessy (1983). However like health education (anticipatory guidance), there are suggestions that health visitors should contribute to the mothers' social network system before childbirth (Court, 1976 and Barber, 1977).

Once the health care needs have been identified or perceived the clients may require further relationship-centred types of skills, such as <u>emotional support, counselling or crisis counselling</u> all of which are frequently mentioned when recording what health visitors do. However

there is limited research describing how and with what effect health visitors use these skills in practice?

Strehlow (1978) thought that many health visitors did not realise that they needed continual education, especially in the basic skills of counselling, until some years after qualifying. Perhaps health visitors' counselling skills have been limited by the confusion caused by the varying definitions of counselling; three are reproduced below from Thinking about Health Visiting (RCN, 1983):

> (a) it can mean the offering of advice or counsel;
>
> (b) it can be the act of communal deliberation, consultation, exchange of opinion; the result of which may lead to action;
>
> (c) it also refers to that activity in which through an interaction between two persons (i.e. the counsellor and another)-the other may be enabled into self-determination and self-discovery. This can also be termed an educational process which affects both persons.

The British Association of Counselling (BAC, 1981) has determined rigorous standards for counsellors, whether they are working as counsellors, or counselling within another profession; these include a formal training or experience under supervision, an on-going arrangement for consultation or supervision and participation in support and personal growth groups (BAC, 1981). How does this affect health visiting? Health visitors experience varying quantities of communication and counselling skills training, and supervision of these skills in their training. The student is certainly introduced to the skills of making relationships and listening: two essential skills in counselling. However it appears that many health visitors find this inadequate to meet the realities of the work situation; many look for counselling courses after completing their training. The Family Planning Association, Marriage Guidance Council, The Westminster

Pastoral Foundation, the Professional Organisations (The Royal College of Nursing and The Health Visitors' Association), and Further Education Colleges all offer counselling courses which are attended by health visitors.

Bourne wrote a revealing and thought provoking letter to the Health Visitor (1981) in which he questioned the health visiting profession's commitment to the development of counselling skills. Apparently Bourne organised a course of 30 weekly seminars for health visitors at the Tavistock Clinic, London. Fifty one health visitors had shown an interest in his seminars, but only eight actually attended. Bourne wrote to all the non attenders and asked why they had not followed up their original show of interest, and why they had not been able to attend. They provided varying reasons which included, especially, financial implications and minimal support from their colleagues and nursing management.

Bourne maintained that other professions were able to attend comparable seminars, and some professionals travelled across the country weekly for between two to four years to do so. He emphasised the pity, if health visitors were lagging behind these others and felt it was up to the health visiting profession to decide whether he had merely met good housekeeping and healthy scepticism of the value of these type of seminars. Bourne raised an important point about whether health visiting management considered that health visitors' attendance at counselling courses was important or was this a low priority which did not warrant the time and cost of attending a 30 week course.

The above comments lead into the second and third points of BAC's training, as follows. The supervision of counselling is time consuming and demanding for both the health visitor and the supervisor, but allows

opportunities for reflection about ones´ counselling work, which in turn enhances the health visitors understanding of the clients problems. Supervision is valuable too as part of the continuing education of the health visitor, which would of course benefit other clients too. The question is who supervises health visitors in their counselling activities, do the nurse managers, and if so have they been prepared for this work? Similarly where are the health visitors support groups? This is a continual cry from all over the country, and yet few health visitors seem able to initiate and maintain such a group, two, however, have been described by Spicer (1980) and Goodwin (1983). Why do health visitors find it difficult to attend these groups when they do exist? Do health visitors feel guilty about attending these groups, because they are perceived as a luxury which is not directly associated with patient care. . Perhaps health visitors (and possibly their managers) do not appreciate that attending these groups and sharing their experiences with other colleagues could clarify their understanding of human behaviour, and improve their counselling skills and professional relationships.

It is, however, notable that in Home - Start, Van der Eyken (1982) described clients´ suggestions that health visitors and social workers used "distancing" techniques in their professional relationships with them. Clulow (1978) explained distancing as a "defence mechanism" for coping with stressful situations. Menzies (1970) observed this phenomenen amongst hospital nurses; she noted that nurses erected defences against psychological pressures. Recently Edelwich and Brodsky (1980) described a condition called ´burnout´, which seems to be experienced by the helping professionals when they do not protect themselves from being emotionally drained. It is a total

loss of purpose, idealism and enthusiasm due to emotional exhaustion, and an imbalance between demands and resources.

3.11. NEEDS AND SKILLS

Despite health visitors' education, and the discussions about the principles of health visiting, it appears that the consumers or clients are not totally satisfied or convinced that they are receiving the support and care that they need or have been encouraged to expect. Evidence supports the clients' views and shows that health visitors are not using the above skills consistently to cope with the clients' health needs, as follows.

Orr's study (1980) Focus on Health Visiting was a consumer view of health visiting in Northern Ireland. She tried to examine the consumer's perception of the relevancy of health visiting. In a sample of 68 mothers, 38 thought the health visitor might be able to advise on mothers' problems such as depression. However only six mothers said they would ask the health visitor for this help, because the mothers thought that health visitors' primary concerns and skills were for their children.

Interestingly, Warner (1983) studied health visitors working in clinics. She observed that, generally, health visitors did not provide the mothers with opportunities to express their feelings, or talk about problems with their own health; the mothers were only encouraged to discuss their children, and if mothers started to raise issues about their own health or gave signals that they wanted to raise issues about their own health, the health visitors invariably turned the conversation back to the child.

The points raised from Orr's and Warner's research about health

visiting are further emphasised by Goodwin's article about the health visiting role in prevention, in the British Medical Journal, in 1982. Goodwin is now the General Secretary of the Health Visitors' Association, which has many health visitors amongst its membership, although the article was written when she was a practising health visitor. In the article she stressed the health visitors' traditional and current role in prevention; she discussed the health screening of children and other vulnerable groups, but she did not single out, nor imply any concern about emotional illness in mothers or anyone else. Snaith (1982) was worried about Goodwin's article, as it made no mention of postnatal depression, and this omission led him to believe that health visitors were not interested in psychiatric disorders.

A workshop for health visitors took place in the Northern Regional Health Authority between June 1981 and June 1982. Its aim was to set standards for health visiting practice. During one month, in that year, 20 health visitors kept a record of visits they made to the 0-5 year old age group (excluding primary visits) during a specific period of the year. Nine hundred and fifty one visits were made, of these 792 (83%) were initiated by the health visitor, 111 (12%) were initiated by the mother, and the remaining initiated by others. Very interestingly only 12 (1.0%) of the health visitor initiated visits were for the follow-up of postnatal depression whereas seven (6.0%) of the 111 mothers requesting health visiting did so because of depression or illness (McClymont, 1982). These figures may indicate different perceptions of health visitors work: with the mothers believing that health visitors can help with their emotional health needs whereas health visitors either do not recognise mothers' emotional health needs or do not consider that they are a priority.

Legislation makes Health Districts responsible for providing a health visiting service which offers advice on health needs. These health needs change over the years as evidenced by the decrease in infectious diseases and the apparent increase in illnesses associated with affluence and living style. Owen (1977) emphasised that for health visiting to continuously respond to the changing needs of the community, it was essential to define both the health needs and the skills required to meet them.

There are few studies in health visiting exploring both the needs of a particular set of clients, and the skills required to meet their needs. This is important as "Nursing Standards" have recently been defined in terms of, how well an individual nurse (health visitor) meets the needs of an individual patient (mother) (Royal College of Nursing, 1980). Two studies considering both needs and health visiting skills are, firstly, Harrison's Stress in Children (1979), which described the health visiting care needed by parents of children with Cystic Fibrosis, and, secondly, Luker's An Evaluation of Health Visiting (1981), concerned with problems of the aged. The latter research described a geriatric population which had had their health needs identified and their health visiting care carefully planned to meet these needs. The entire project was experimental. The results included some discussion of the value of health visiting as seen by the consumers, but the bulk of the results explored the effectiveness of health visiting care which had been planned after the identification of the health needs.

Dominian believed that postnatal depression was generally an unmet need which could be detected and managed using the correct skills (1976).

The research discussed in the present and the previous chapter

indicated that postpartum mothers have needs for health care which is relevant to postnatal depression. The mothers' needs may be expressed subjectively, or defined by the professional carers. It seems that mothers are looking to health visitors for this care. There is also evidence that health visitors have some knowledge and a variety of skills which are suitable for finding and caring for postnatally depressed mothers. However there is uncertainty about how these needs can or should be identified in practice, and whether health visitors are adequately trained to meet them. The literature review in the present chapter has indicated that health visitors have made working with children their priority and it is unclear whether in practice this has been extended to include work with the children's mothers and their families. These questions and those raised in Chapter 2 led to the research described in the following chapters.

CHAPTER 4

THE RESEARCH DESIGN

4.1. EXPLORATORY STUDY

Some time before the author commenced the present study, she made a preliminary examination of the incidence of puerperal mental illness during the preceding year, in a part of the health district later used in the main study (Hennessy, 1978).

In that preliminary investigation a number of health visitors working in Portsmouth and South East Hants Health District were chosen to participate and complete a simple questionnaire. The questionnaire had only seven questions, requiring the health visitors to give professional opinions about the emotional health of those mothers in their care who had had a baby in the preceding year. If the health visitor expressed an opinion that the mother had suffered from puerperal mental illness, she was asked to categorise this into one of three groups: "the blues", postnatal depression or puerperal psychosis. Twenty seven out of 36 health visitors (80%) invited to do so, participated. These health visitors expressed opinions about 1,402 mothers.

The results of this study showed that during the preceding year each health visitor had cared for an average of 58 mothers post confinement. The health visitors thought a total of 61 mothers out of 1,402 (4.3%) had suffered from postnatal depression. This was fewer than expected at that time in the light of previous research. Both Pitt (1968) and Watson (1978) had estimated that the incidence of postnatal depression was about 10%.

The exploratory study revealed that 75% of the mothers said to be depressed had received help from the health visitor and 68% from the

family practitioner, only 12 mothers (less than 20%) had psychiatric assistance. This corresponded with information given by a general practitioner at a community health seminar at Knowle Psychiatric Hospital in February 1978; he said he treated 80% of his cases in the community without referral to Psychiatrists (Southern, 1978).

4.2. THE WAY FORWARD

The exploratory study showed the lack of reliable information concerning the incidence of postnatal depression. The discrepancy highlighted above showed the possibility of variability of maternal emotional health, with time and geographical area. Perhaps, too, health visitors' perceptions of mothers' feelings were less accurate than Pitt's test. Or, on the other hand, it was possible that the tests were not as accurate as the health visitors' impressions, for they may have had better understanding of mothers' feelings. The difficulty of assessing maternal emotional health in the absence of standardised screening methods became apparent. A review of the literature concerning postnatal depression suggested that the most useful basis for assessing maternal emotional health was to categorise and define the mother's own feelings according to Pitt's 4 criteria: the mother would have felt depressed for more than two weeks since her confinement, she would have at least two accompanying symptoms which would be disabling to some extent and the mother would feel different from usual.

The lack of information about certain areas also became apparent during the literature review; for example a clear understanding of the health care needed by postnatally depressed women. Although it was assumed that health visitors had an important role in providing the professional health care required by these mothers, unfortunately there

seemed to be very little information about what health visiting care was actually offered. Therefore it appeared advisable to plan several concurrent investigations. Firstly, a systematic enquiry into the incidence of excessive anxiety and depression in puerperal women and the associated psychosocial factors. Secondly, to consider the health care required for the problem. Thirdly, to examine the care given by health visitors, with particular regard to health visiting skills.

Thus the objectives of the research were to ascertain:

(a) The incidence of postnatal depression using various measurements.

(b) The duration of the depression, when it starts, ends and the associated symptoms.

(c) Whether health visitors could identify mothers who were "at risk" of developing postnatal depression, and whether they recognised all those mothers who suffered from this problem in the year following their confinements.

(d) What skills health visitors used to screen and identify these women.

(e) What preventive methods health visitors used for those mothers "at risk".

(f) What skills health visitors used to meet the needs of the women who had postnatal depression.

(g) Whether, or where the health visiting service should be improved in this area.

4.3. PLANNING THE RESEARCH DESIGN OF THE STUDY

The research was planned as a longitudinal prospective study of a sample of over 300 women living in one health district, from the seventh month of their pregnancy until the fifteenth month after childbirth. Information was sought from the mothers themselves, their health visitors, their midwives and general practitioners. Information was collected in recording schedules, questionnaires, client diaries, psychiatric screening tests and by participant observation. The reasons for choosing a longitudinal study, the various research techniques and the method of sampling will be discussed in the following paragraphs.

The Reasons for Choosing a Longitudinal Study

Postnatal depression is described as depression developing during the year after childbirth, and the literature review revealed the variations in onset and duration (Pitt, 1968; Kumar & Robson, 1982 and Cox, Kendell et al, 1982). As periods of depression could occur at almost any point in the puerperal year, and might be of comparatively short duration, a longitudinal study would be an effective and economical way of covering these episodes.

As the literature had shown the potential value of the mothers' own assessments of their mental health, they were asked to describe and comment on the state of their emotions during the whole postnatal year, and this was done both by answering a questionnaire and by recording their associated needs in a "client diary", which they kept for the second six months of the year.

The present research was designed to be compatible with other studies (Pitt, 1968) and for mothers to complete psychiatric screening

tests during their pregnancy, in the early weeks after confinement and again 1 year later, this also required a longitudinal approach.

The present study was concerned especially with the health visiting care of these women and this too had to be examined over a period of time, which required a longitudinal study. Health visiting is concerned with maximising the health of individuals, which is encouraged by continuous routine contact at vulnerable stages of life, rather than only at times of crisis. Families with young babies have many stresses and health care needs and they can be termed a vulnerable group; therefore health visitors have very close contact with them, for at least 2 years, and usually continuing until all the children in the family have entered school.

Few studies in health visiting have considered any aspects of this long-term caring approach. Clark (1981) summarised most studies investigating health visiting and mentioned no longitudinal investigations, more recently, however, Luker (1982) studied the health visiting care of an elderly population over a period of 4-6 months. The present study gave the opportunity of investigating the care that a sample of women received from their health visitors over a whole year and thus adding to our knowledge of care in practice.

Health visitors do not work in isolation; they are only one of three members of the primary health care team caring for childbearing mothers. In the health district where the research took place there were well-functioning primary health care teams. The co-operation within such teams means that information gathered by one member is normally available to the others, and this provides a good base for building knowledge and gaining understanding of puerperal mothers. A longitudinal study should make it possible to tap this body of

information in a way which would not have been so feasible in a cross-sectional study, chiefly because there would not have been time to build up the necessary confidence between researcher and primary health care teams.

The midwives usually contribute to the mothers' antenatal and immediate postnatal care, thus getting to know them well; during this association the midwives gather information which could enhance the mothers' health visiting care. Therefore information from the midwives was included in the health visitors' recording schedule, at the start of the longitudinal study.

Information was also sought from the family practitioners. As noted in the literature review they have had a long history of helping mothers with minor health problems. They may supervise the mothers' antenatal care, their deliveries, and often visit mothers and babies shortly after the mothers' confinements. They frequently provide a postnatal medical check for the mothers and their babies, 6 weeks after chilbirth. Additionally, the mothers may, at any time, seek medical treatment from the family practitioners for themselves, or their children. Therefore information was collected from the family practitioners at the end of the study in a questionnaire.

Difficulties with a longitudinal study

Two particular problems associated with longitudinal studies were carefully considered during the planning stages. Firstly thought was given to the possibility of "the loss of subjects".

> "When a group of individuals is observed over a period of time, there is always a problem of maintaining contact with them. Families may move out of the neighbourhood and their moves are often difficult to follow." (Goldfarb, 1960, p.55)

If a mother moved out of the district it would have been necessary

to negotiate ethical approval and permission from her new District Health Authority, Family Practitioners and Health Visiting Service to keep her in the present study. This was not considered feasible in a single-handed research project, so mothers were not followed up if they left the health district. This was unfortunate for the present study, which took place in a health district with much mobility, as described later in this chapter. The sample size in the study was planned to cover the estimated loss of mothers, but could not allow for any possible differences in the health, character or circumstances of 'movers' as against non-movers and this is discussed further in the section on Sample Response at the end of Chapter 4.

The second problem concerned "the frequency of interviewing", and its negative effect on maintaining the interviewers' and interviewees' interest in the project. Care was taken to overcome this in the study and it is discussed later in the chapter.

4.4. INTRODUCTORY INFORMATION ABOUT RESEARCH METHODS

This section gives some basic information about the research methods, but the way the methods were used in the main study is described in Chapter 5.

Recording Schedules and Questionnaires

In this study recording schedules were defined as forms that are completed by someone about someone else, whereas the questionnaires were forms completed about oneself.

There were 3 recording schedules, 2 completed by health visitors and one by the family practitioner.

Health Visitor Recording Schedule 1 (HVRS 1)

The first recording schedule (HVRS1) completed by the health

visitors was designed to cover many questions raised in the literature review in Chapters 2 and 3. For example Pitt (1968), Blair et al (1970) and Dalton (1980) noted that although age, marital status, previous marriages, number of children and the patient's relationship to her husband appeared clinically to be connected to postnatal depression, little statistical evidence had been found. Nevertheless, most of these items were included in this research mainly because all this information is easily accessible to health care workers and it was possible that new correlations might be found; therefore many associated questions were included in the first Health Visitor Recording Schedule.

Also mentioned in the literature review were Ritchie's (1977) list of subjectively and objectively described symptoms. The subjective factors included physical disturbances (such as reduced appetite, loss of libido, loss of weight), emotional disturbances (such as sadness and crying spells) and cognitive disturbances (such as self-criticism and inability to cope with the infant's needs). The objective factors include facets of appearance (such as posture, speech, weight loss) and activity (such as slowing down or agitation). Section C of the first Health Visitor Recording Schedule is based on this list of symptoms (see appendix - Health Visitor Recording Schedule I, Regular version). Ritchie emphasised that the physical or somatic factors may be difficult to ascribe to depression because of the physiological and environmental factors following parturition. Disturbed sleep due to night feeding is one example. The question "at night, does she wake at times other than when the infant cries" attempts to avoid this difficulty. Similarly a certain loss of weight is expected during the puerperium and hence the question "is her weight loss more than would normally be expected after the birth of the baby" (Health Visitor Recording Schedule 1 - Section C

- Regular version, questions 2b and 1b respectively).

The questionnaires and recording schedules were designed to collect relatively specific information, and to provide considerable opportunities for interpretative comments by the respondents completing the forms.

Participant Observation

The research technique of Participant Observation was used to investigate the health (visiting) care of mothers and the health visiting skill of "searching" for health needs. Although the literature includes few references to studies observing health visitors at work, participant observation has been used in other "health worker-patient interaction studies" especially Byrne and Long (1976) and Kratz (1975), and more recently in Warner's study of health visiting in clinics (Warner, 1983). Warner's work only became available after the fieldwork of the present study had been completed.

The method is particularly useful for exploring complex social processes and relationships which are difficult to measure either whole or in parts, such as nursing (Fox, 1966). Quint (1967) said the method was not appropriate for testing hypotheses from a formal theory, but could be used to develop a conceptual framework for understanding, and explaining, what really takes place in the realm of patient care. In the present study this applied to "the search" for mothers' emotional health needs, and was used to obtain an independent view of what took place during the contact Health Visitors are recommended to make with their clients six months after childbirth.

Jackson (1975) in a paper on her experiences of using the participant observation while researching for a doctorate, suggested

that a review of the literature revealed little analysis of the method. She thought it was rather difficult to do so, or even to define the method, as it can be so variable. However Gold (1958) described 4 ways of being a participant observer:

1. a complete participant, when the investigator interacts with those he is investigating;
2. a participant as observer, in this situation the observer and the observed are aware of the situation and the roles are well defined;
3. observer-as-participant demanding formal observations usually during only one contact and
4. the complete observer where the investigator attempts to observe people in such a way that they do not know he is doing so.

In some of the above roles it may be difficult for the investigative nurse to be objective (Quint, 1967). This point was also noted by Kratz (1978) when investigating the nursing care of the chronically ill in the community. Baker (1978) discussed these constraints and described how she negotiated her role as participant observer in her research project. It would appear that nurses doing the investigating in a study, using this method, are often persons well known for their interest, or ability in the particular subject being observed. Therefore it is difficult, and requires considerable care and planning, to maintain the chosen participant-observation role of the research design; particularly not to participate or intervene in the nursing care. It is unusual to use "participant observation" as a research method in a study which also uses questionnaires, but it was appropriate in this study as it aided the understanding about what

happened between health visitors and others in a given set of circumstances, as mentioned above. Moser and Kalton (1971) thought that participant observation was an individual technique which depended on skill and personality and was very useful when supplemented by other methods. Such a combination of research methods was used successfully by Mckee (1982) in a study of fathers.

Although information collected during participant observation seldom produces definitive answers, the method opens up areas which may be very diffficult to research by any other method.

Tape Recorders

These were used to record the verbal interaction between the health visitors and mothers during the observed visits. Some time after the fieldwork of the present study the method of using tape recorders in health visiting research was well documented by Warner (1983) and Clark (1984). They both showed that the method had a good level of acceptability and little usage difficulty. Clark specifically mentioned that neither clients nor health visitors perceived much change in their behaviour as a result of using the tape recorder in visits. Clark also maintained that it was possible to meet all ethical requirements using the tape recording method.

The biggest difficulty is presented by the practical problem of processing the information, which requires many hours to transcribe to paper. Thereafter the transcriptions require interpretation, which can be complex, particularly in health visiting with its variety of approaches to different clients.

In the present study the author was only interested in the health visiting concerning the mothers' health. It was therefore planned to

transcribe only the portions of the tapes concerned with any aspect of the mothers´ life and health. This eliminated all references to the childrens´ health, unless mentioned in some way as affecting the mother.

4.5. DESCRIPTION OF TWO PSYCHIATRIC SCREENING TESTS AND REASONS FOR THEIR CHOICE

Although this study was essentially about the health visiting care of mothers, and the mothers´ own opinions of their depression were considered very important, it was also necessary to have independent measurements of postnatal depression. Two psychometric tests were chosen and are decribed below.

Pitt´s Anxiety Test (PAT)

Pitt (1968) developed a diagnostic tool called Pitt´s Anxiety Test, which is used as a screening test to measure the presence of anxiety, or depression, in women after childbirth. This test has been replicated in subsequent investigations including Breen (1975) and the present study.

Unfortunately Buros (1978) did not include it among the tests which he dealt with in his review of tests of postnatal depression, but the author of the present study has been unable to find any serious criticism of the test in the literature. Its origins and purpose made it an obvious choice to use in the research.

Pitt´s Anxiety Test is a questionnaire designed to be completed by women in their twenty-eighth week of pregnancy, and again six to eight weeks after childbirth. It relies on comparing the women´s feelings in pregnancy with their feelings after their confinement.

The important point is not the score obtained by a woman on the

initial test but whether it increases or decreases after childbirth. The test is a relative, rather than absolute, measure of depression against normality; it attempts to measure the difference between how the mother feels before, and after childbirth.

There are twenty four questions in the Test which are based on clinical experience of depressive illness and the special anxieties of childbearing women. The questions concern current feelings and experiences, and are answered by "yes", "no", or "don't know". They measure twelve hypothetical 'factors'. There are two questions per factor, one expecting the morbid answer "yes", and the other "no". The factors include depression, general anxiety, guilt, irritability, hypochondriasis, depersonalisation, retardation or slowness, cognition or understanding, dependency upon people, sleep difficulties, and loss of libido.

The test is introduced by a brief reassuring explanation of its purpose and ends with an invitation for the spontaneous expression of feelings. The scoring method, with a maximum score of forty eight points, is easily remembered (Pitt, 1968). Pitt considered a minimum increase of six points in the test-score postpartum indicated the presence or future likelihood of postnatal depression. He classified the women whose score increased by less than six points as a doubtful group.

Reliability

Pitt tested the reliability in a pilot group of forty subjects, giving them the questionnaire twice in pregnancy, at the twenty-eighth week and thirty-fourth week. Re-test reliability was indicated by the correlation between the scores on these two occasions. This was

assessed by Pearson Bravais's product moment correlation and found to be significantly high: + 0.76 ($t = 7.2$ $p<0.001$ for 38 degrees of freedom).

Validity

Pitt validated his Anxiety Test by taking forty subjects in roughly equal proportions from the antenatal clinic, maternity wards and postnatal clinics. Each subject was given the questionnaire and then interviewed. The interviewer, ignorant of the questionnaire score, rated them according to a scale based upon the Hamilton Rating Scale (Hamilton, 1960) for Depression. Subjects were then ranked according to their clinical rating and questionnaire scores. The correlation between their ranks on the two assessments indicated the validity of the questionnaire. Spearman's rank correlation was significantly high: 0.78 ($t = 7.7$, $p<0.001$ for 38 degrees of freedom).

Means and Standard Deviations of the scores

The means and standard deviations In Pitt's study were calculated from the scores of the first one hundred and sixty four subjects who had completed the questionnaire in maternity wards and postnatal clinics, at 6-8 weeks post childbirth, as shown in Table 1 below.

It was interesting that mean scores in Table 1 seemed to decrease so that increases of six points were relatively noticeable.

TABLE 1
PITT'S ANXIETY TEST
MEANS AND STANDARD DEVIATIONS

Source of Response	Stage of Motherhood	Mean	Standard Deviation
Antenatal clinic	Pregnancy 28 weeks	14.46	7.9
Maternity ward	Post-confinement 7-10 days	11.89	7.7
Postnatal clinic	6-8 weeks	11.82	7.9
Antenatal clinic*	Pregnancy 34 weeks	15.60	7.3

NOTE * This group were part of the total 164 mothers but are liste separately because they completed the questionnaire twice in pregnancy to
allow for an assessment of re-test reliability, Pitt (1968).

SOURCE: Pitt, 1968.

Selection of a Further Test for Screening Depression

All the mothers who had scored an increase of six points in Pitt's study had a psychiatric interview. During this interview the mothers were urged to explore their feelings and an index of depressive symptoms and their intensity were scored on the Hamilton Scale; additionally the Maudsley Personality Inventory was administered to give an indication of the mother's previous personality. Pitt was unsure after using the latter whether it was valid for this type of study. Breen (1975) used Pitt's Anxiety Test on its own to assess postnatal depression whereas Blair et al (1970) and Playfair and Gowers (1981) only searched for certain symptoms and Wolkind and Zajicek (1978) confirmed depression by using the Rutter Malaise Inventory.

In the present study the author thought that a further psychiatric screening test was required to support the findings of Pitt's Anxiety

Test, and after reviewing the literature and discussing the various tests with a clinical psychologist the author considered the Hamilton, Beck and Zung scales.

The Hamilton Scale did not seem to be an appropriate test to use in this study. This was because it is a scale useful in providing a simple assessment of the severity of a patient's condition, and for showing the effects following treatment. However the criteria of the present study required that a process of change and its effect on the mother's feelings be identified, rather than the severity of depression in individual mothers. Further the Hamilton Scale is completed by a 'rater' and the value of the ratings depends on the skill and experience of the rater (Hamilton, 1967 and 1969).

Psychiatric screening tests were scrutinised to find one that could be used with Pitt's Anxiety Test and easily administered in the community. These included the Beck Inventory which, although a self-assessment rating, needs an interviewer to expand and explain the questions. However this test had been validated on a sample of patients in a psychiatric hospital of whom more than a quarter were schizophrenic (Beck et al, 1961 and Beck, 1973). In contrast the present study took place within an average community and Beck's Inventory therefore seemed inappropriate.

The Zung Self Rating Depressive Scale might have had some advantages because it is short and simple to complete, but as it was developed specifically for ill patients, it was again unsuitable for the average community, (Zung, 1965). The Crown-Crisp Experiential Index, (Crown and Crisp, 1979), was found to be the most suitable test and is discussed further in the next section.

Crown-Crisp Experiential Index (Crown and Crisp, 1979)(CCEI)

The Crown-Crisp Experiential Index was chosen as it was designed to provide personality profiles, measure change, and screen for psychoneurotic traits in general practice and population studies. A total score can be obtained to provide a measure of general emotionalism or neuroticism, together with a profile of six sub-scale scores. The sub-scales measure free floating anxiety, phobic anxiety, obsessionality, and somatic concomitants of anxiety, depression and hysteria.

The two sub-scales of particular interest to this study were:

1. Free-floating anxiety, which means, "the patient is afraid but unlike normal fear there is no discernible object of which he is afraid".

2. Depression, which means, "sadness of mood, difficulty in thinking clearly and slowing of actions and activity".

The test notes differences in the scores of males, females and age groups which are relevant to this research which was confined to females of childbearing age.

Reliability

Reliability was tested in repeat and split-half methods. The coefficients vary between 0.68 and 0.77 in one test, and 0.50 and 0.84 in another test on a smaller sample. The test was found to be repeatable and consistent over time (Crown and Crisp, 1979).

Validity

Two large studies of normal populations were used to validate this test. One sample was taken in a small market town and the second sample

in a city area.

The CCEI profiles of the two samples, in terms of mean sub-scale scores, were compared with those of a defined psychoneurotic population and four clinically diagnosed groups that were specific to four of the individual subscales, namely the free-floating anxiety, phobic, obsessional and depressive scales.

There was a remarkable similarity between the scores of the rural and city samples, which suggested the feasibility of using the test for screening surveys.

The test authors suggested that five to ten per cent of the normal population in the validation studies scored as high, or higher, than the mean scores of the definitively psychoneurotic population, and this figure is consistent with those cited by Hicks of the clinically identifiable psychological morbidity in general practice clinics and populations (Crown and Crisp, 1979, p9).

Means and Standard Deviations

Table 2 shows the means and standard deviations of two sub-scales - Anxiety and Free floating depression; Crown and Crisp derived these and other subscale scores during their General Population Study (Crown and Crisp, 1979, Table 7, p17). In their discussion of the scores Crown and Crisp (1979, pp.17-19) noted that females showed particularly high mean levels of anxiety in the age bands 25-44 years, which decreased in the post-menopausal years (44-64 years). On the other hand the mean scores for depression increased with age, with the peak in the post-menopausal years which contrasted with the lower anxiety scores at this age.

TABLE 2

MEANS AND STANDARD DEVIATIONS
GENERAL POPULATION STUDY
CROWN-CRISP EXPERIENTIAL INDEX
SUB-SCALE SCORES

Age in Years	Free-Floating Anxiety			Depression		
	Mean	SD	Number	Mean	SD	Number
17-24	4.0	3.4	28	2.0	1.6	28
25.34	6.6	4.3	68	3.7	2.8	67
35-44	6.2	3.9	72	3.8	2.7	72
TOTAL 17-44	6.0	4.1	168	3.5	2.7	167
Menopausal Years						
45-54	5.5	3.8	76	4.1	2.7	76
55-64	4.5	4.0	74	4.0	3.1	74

SOURCE: Selection from Table 7 for Females, in Crown and Crisp, 1979.

Buros (1978) discussed Crown and Crisp's honest and comprehensive description of their test and its limitations. They raised two aspects. Firstly there was the possibly slight negative relationship between intelligence and the test scores; they thought that more intelligent respondents might see through the questions, and bias their answers to a socially desirable response. Secondly, they also noted the disadvantages of any test grounded in clinical psychiatric practice, which naturally reflects the values of the descriptive psychiatry upon which it is based; most relevant to the Crown-Crisp Experiential Index is the confusion in clinical practice between a symptom and a trait. The test authors stressed that a symptom was something of which a patient complains (eg anxiety) and a trait was normally seen as an

attribute of personality whose distribution in the population is normal. Thus anxiety, phobic anxiety, depression and hysterical phenomena if severe, are all looked on by psychiatrists as symptoms. In other cases they can be seen as a personality trait and sometimes when severe, as a personality disorder (Buros, 1978).

Discussion of both Pitt's Test (PAT) and the Crown-Crisp Experiential Index (CCEI)

The PAT and CCEI test can be used to obtain in a few minutes an approximation of the likely diagnosis obtainable from a psychiatric interview. The Crown-Crisp Experiential Index measures the mother's mood at the time of the test rather than change of mood as in Pitt's Anxiety Test. Neither test excludes mothers who may have been depressed for some time, such as before becoming pregnant.

Both tests use simple English and are designed to be completed easily by the mother (or patient) herself and can be administered by clerical personnel, who only need to ensure that all the questions are answered.

In the present study the results of these two standardised tests could have been used on their own to describe the incidence of excessive anxiety, depressed feelings or postnatal depression, however it was desirable to complement them with data obtained by more traditional means. These included the opinions of the Primary Health Care Team, ie the midwives, health visitors and the family practitioners who looked after these mothers. Even more important were the mother's own subjective feelings about her state of well-being; these mothers may have had specific emotional health needs requiring care without having a psychiatric disturbance; or they may have suffered from chronic

depression for some time before having the baby, and yet have adjusted to the changes after childbirth satisfactorily. Therefore additional information about the mothers' emotional health and the health visiting care they received, was collected using further methods which are described in detail in Chapter 5.

4.6. DESCRIPTION OF THE AREA

The Wessex Regional Health Authority was established under the National Health Service Reorganisation Act 1973. The region was divided into area health authorities which were further sub-divided into health districts. The research took place in the large Portsmouth and South East Hampshire Health District which was a part of the Hampshire Area Health Authority (Teaching). In the 1982 NHS reorganisation the District was made into a Health Authority in its own right but this did not affect the research.

The Portsmouth Geographical Survey (1977) illustrated the distribution of the Community and Medical Services, and also described how the pattern of health and welfare services such as child health clinics and family practitioners' surgeries, had been determined by the age structure of the population in various districts. The location of these services and the distribution of the population by age, is illustrated in the survey maps.

There are also maps illustrating the distribution of the socio-economic groups, and showing a certain segregation. However there was some mix, especially around the seafronts of Portsmouth and Southsea where there are flats and bedsitters. These are interspersed with tracts of large residential houses, and are very close to local

authority housing in Portsmouth and the naval housing in Rowner, Gosport.

The naval estate of Rowner is only one of a number of naval housing estates in Portsmouth Health District. The concentration of naval housing increases the normal mobility of families in the area because of the Royal Navy Drafting Cycle. During this cycle a sailor spends approximately 30 months on a ship, this time is alternated with shore time. The shore time varies from nine months to two years. Time away from the home port varies with the programme of the ship, and may be days to months. When the sailor's cycle changes he may be drafted to shore time or a ship based at another port; the sailor's family usually move with him, when he is based at other ports.

If the sailor's ship is Portsmouth-based the family often live on one of the naval estates. However, when the ship is away for a period of time and the children are under school age, the sailors' wives again and again return with their children to the maternal grandmothers in other parts of the country. Oglesby (1978) discussed the effects of mobility on the sailors and their families in the Portsmouth area, especially how the naval requirement to move the men around the country affected their retention in the Navy. If a sailor leaves the navy he and his family frequently move out of the Portsmouth Health District and return to their original home area.

From the point of view of the health visiting service the most directly relevant characteristics of the district population were:

1. The mobility of the mainly young naval families, with their comparatively high birthrate (the crude birthrate in Gosport was 22.3% in 1971), and lack of support from an extended family.
2. The much lower birthrate in Portsmouth itself (14.1% in 1971).

However 14% of these births were illegitimate, a fact probably related to the higher percentage of single person households, students and older persons living in flats, converted bedsits and privately rented accommodation, in the inner-city of Portsmouth.

The author tried to establish figures of unbooked mothers (that is mothers who received no ante-natal care) and was informed by the Director of Midwifery Services that these hardly ever occurred in Portsmouth Health District. Similarly in this district most persons were registered with a family practitioner, and there were no district figures for those who were not registered. In the areas with higher birth rates, such as naval estates, health visitors possibly had higher case loads of new babies and mothers, whereas in the inner city areas they may have had more families with social problems. Efforts were made at least annually, within each sector, to balance each health visitor's case load, by considering the varying work needed by these clients.

4.7. THE COLLECTION OF INFORMATION

The timing of the different stages of information collection, over the eighteen-month period was chosen to match the normal contact times between the mothers and the community health staff, so as to maximise co-operation from both.

The longitudinal study commenced in the mothers' 28th antenatal week, because the first part of Pitt's Anxiety Test needed to be completed at this time. Fortunately during the twenty-eighth week of pregnancy women usually have a blood test; blood is normally taken at the antenatal clinics in the family practitioners' surgeries, or at the maternity hospitals.

Similarly the other stages of two weeks, six weeks, six months and one year after childbirth are recommended contact times between health visitors and mothers, in the health district in which the study took place. Further information was collected directly from the mothers, thirteen months after their confinements, and was especially timed to avoid a first year anniversary reaction, as some mothers may perceive the birth of their baby as a "loss"; it is well known that anniversary dates of loss or bereavement may be painful experiences (Parkes, 1972, p 206) or be associated with depression (Raphael, 1978).

The specific months when information was collected were chosen to miss the major holiday periods of July and August when both the health care staff and the mothers may have been away.

The timing of the Family Practitioner contribution was also important so that the health visitors who arranged for the completion of these recording schedules were not overloaded with work. There was no difficulty in keeping within all these constraints by using the mothers' confinement dates in the months of April, May and June as the focal point. The sequence of operations is summarised in Table 3 below.

TABLE 3

THE COLLECTION OF INFORMATION

Times	Research Methods	Collected/ Administered by
28th prenatal week	PAT I	Midwife
Birth, 2nd and 6th postnatal weeks	PAT II	Health Visitor
	CCEI I	" "
	HVRS I	" "
6 months	Participant Observation	Investigator
	Tape Recordings	"
	Check Lists	"
	Client Diaries	Mothers
1 year postnatal	HVRS II	Health Visitor
	HV Records	
13 months postnatal	Mothers' Questionnaire	Mothers
	CCEI II	HV/Investigator
	Client Diaries	Mother
15 months postnatal	FPRS	FP/HV

PAT - Pitt's Anxiety Test
CCEI - Crown-Crisp Experiential Index
HV records - Health Visitor Records
HVRS - Health Visitor Recording Schedule
FPRS - Family Practitioner Recording Schedule

4.8. SAMPLING METHOD AND SAMPLES

The decisions determining the sample size and the methods of sampling are given in the following paragraphs.

Deciding on the Sample Size

The choice of sample sizes was guided by two pieces of information, namely the 10.8% incidence of postnatal depression claimed by Pitt in his study of 305 mothers, and the incidence of 4.3% in 1402 mothers in

the author's exploratory study. In a sample of size 305, the standard error of a sample percentage of 10.8% is 1.8% giving the 95% confidence interval of 7.3% to 14.3% for the estimated incidence of postnatal depression. This was felt to be a reasonable degree of precision; a much larger sample is required to achieve a substantial reduction in the width of the confidence interval (a sample of almost 1000 is needed to reduce the standard error to 1%).

Thus the ideal total sample size for the present study was set at 300. However it was not possible to obtain one random sample of this size given the resources available for the study. It might have been quite easy to randomly sample the 300 mothers in hospital-based antenatal clinics but the present study was designed to collect all the information in the community. Organisational difficulties made it impractical for the author to randomly sample 300 women from community-based antenatal clinics.

Therefore the 300 mothers required were collected in two samples. The size of the random sample of mothers to whom Pitt's tests would be applied was set at a lower figure, with the total of 300 mothers being completed by other sampling methods. The random sample size for Pitt's test was chosen as 100 mothers, this being feasible from the point of view of organisation and expense and also being large enough to give a good chance of obtaining statistically significant results. In fact, if the true incidence of postnatal depression in the population being studied were equal to the 4.3% suggested by the exploratory study, then carrying out statistical tests at the 5% level of significance would mean that there was a better than 50-50 chance of showing a significant difference between the results based on a sample of size 100 and those of Pitt's study.

The two samples were similar with respect to social class, geographical location and the dates of childbirth, and are discussed below.

Sample 1

The mothers in sample 1 were drawn from five practices of family practitioners who had health care teams willing to co-operate in the research project. The practices were carefully selected after discussions with medical sociologists, health service administrators and the local family practitioners, so as to include women (patients) who probably represented the usual population variations in the health district (Portsmouth Geographical Survey, 1977), including social class and living accommodation. All family practitioners chosen held antenatal clinics in their surgeries or health centres.

After a specified date, all women attending these clinics and in the twenty-eighth week of their pregnancy, were invited to take part in the study by the midwives. If they agreed the midwives then administered Pitt's Anxiety Test.

The midwives continued collecting consecutive cases until the collection period elapsed. The period was planned to allow the expected dates of childbirth to be similar to that of the mothers in sample two (see below). The target of one hundred mothers was thought to be realistic for this method of sampling.

The midwives informed the relevant health visitor of the confinement of each mother in Sample 1. This health visitor then became responsible for arranging to complete the 2-6 week collection of information about these mothers.

Sample 2

Sample 2 included the additional numbers to make the total of more than three hundred mothers.

In Portsmouth Health District the midwife in attendance at childbirth routinely notifies the district community physician (see glossary), who in turn informs the health visitors responsible for caring for the new mothers and their babies. As close as possible to the expected dates of delivery mentioned in Sample 1, the first four new mothers of every health visitor in the district, who was not involved with Sample 1, were selected for Sample 2.

The Different groups in Sample 2

Sample 2 was divided into two main groups. One group, called Sample 2a, included the first of the four mothers of each health visitor, and the next three mothers made up the other group called Sample 2b.

This division was required for one of the research methods, namely the Health Visitor Recording Schedule I, which had two versions (Appendix D); the shortened version was completed for mothers in sample 2a and the regular version was completed for those in sample 2b. The regular version contained questions which health visitors may not have used normally. The author wanted to measure differences in health visiting care resulting from the extra questions and their answers.

It was necessary to create a third smaller group, which would be manageable for the research method of participant observation, as a large sample would have been impossible. The author decided that she could manage about 60 mothers, therefore mothers were randomly selected from Samples 2a and 2b, after the six-week visit. The selection was

made from health visitors who had thought that one or more of their four mothers would develop postnatal depression in the months after childbirth. When a health visitor was selected, her four mothers were also selected. This method was to ensure a selection of health visitors who were knowledgeable about postnatal depression, and who might be able to demonstrate how care varied between the patients thought vulnerable to postnatal depression and the other patients.

Due to wastage some of the health visitors had less than four mothers when the random selection was made, and therefore seventeen health visitors were selected with a total of sixty-two mothers. This group of mothers was called the Participant Observation Group.

The sampling response is covered in the following chapter.

CHAPTER 5

THE RESEARCH METHOD

5.1. PILOT STUDIES

The duration of the longitudinal study was eighteen months and it was not feasible to undertake a pilot study of this duration. However the main study followed the normal pattern of health visiting, especially as the timing of the information collection matched routine health visiting contact times. Indeed, perhaps it could be said that the longitudinal system used in this research was in itself a pilot study, because there was no similar previous study.

Therefore the specific aims of the pilot studies were restricted to:

(1) testing the recording schedules and questionnaires and finding any faults and ambiguities,

(2) assessing the possible co-operation of the field staff and the mothers,

(3) detecting any administrative difficulties.

Pitt's Anxiety Test and the Crown-Crisp Experiential Index

Pitt's Anxiety Test I was piloted first followed by Pitt's Anxiety Test II (Appendix A) and the Crown-Crisp Experiential Index (Appendix E). In the pilot study midwives and receptionists were taught the simple procedures of administering the tests. They then offered the tests to a group of mothers, firstly to assess the difficulties associated with the test procedure in antenatal clinics and during health visitor home visits, and secondly, to establish whether mothers in the community were willing to complete them. No difficulties were found.

Health Visitor Recording Schedule 1

This schedule was long and rather complex. It probably required a more intensive questioning approach by the health visitors than they normally used. It was clearly necessary to pilot the schedule, and this was done in another health district. Permission was obtained for the Pilot Study from that District's Nursing and Management Committee including its Ethical Committee, and also its Family Practitioner Committee.

A group of health visitors in one section of this district was visited by the author. The project was explained and volunteers were invited to test the schedule. Twenty health visitors volunteered, and each was given a Recording Schedule 1 with instructions, which they were requested to complete, for the next "primary visit" made to a new mother and her baby. When the three parts of the schedule had been completed they were returned in the stamped addressed envelopes provided. The volunteer health visitors were asked to note any difficulties, and particularly the time they took to complete the schedule. All twenty health visitors returned their schedules declaring, spontaneously, that they had enjoyed participating in the pilot. They estimated that the schedule had taken 10-25 minutes to complete.

The main difficulties they noted were as follows:

(a) Maintaining confidentiality -

Health visitors like other caring professionals are most concerned about protecting the personal information they acquire while caring for their patients. This is extremely important in health visiting where the relationship between the health visitor and the client is carefully nurtured by both parties and may continue for some years.

There are also legal aspects, and a code of ethics in the health service about maintaining confidentiality. In the pilot study names were not required, additionally the questionnaires were not given a code number. However the mothers were asked to sign a consent for participating in the study. This requirement nullified the confidential aspects. Therefore in the main study a note accompanied each HVRS I which health visitors read to the mothers and then noted their verbal consent.

(b) The inadequate space on the schedule for additional comments - A number of questions demanded explanations from the health visitors about why they thought the mothers might or might not become depressed. Space was required for the mothers' comments too. These difficulties were overcome by changing the layout of the schedule.

(c) One health visitor suggested that all the questions should be addressed to the mother. In the main study the author suggested that the health visitors should use the schedules in the manner most appropriate manner for gathering the information required. For example, Question 8a in Part c (Appendix D) - "Does the mother meet other people?" possibly required somewhat non-directive discussions with the mothers to assess whether they were meeting people in their homes or elsewhere.

The health visitors in the pilot study also made a number of useful observations, leading to an extra three questions in the main study. The first question was important. It concerned which persons, in the mothers' social networks, were available to help around the time of childbirth. Therefore Question 6 was included in Part A - "Is there any

help available from the extended family eg mother, mother-in-law or any other?".

The father's involvement with helping the mother was the second point raised. This was covered by including Question 5 in Part C - "Does the father assist the mother?". The third point concerned the health visitor's impression about the mothers' interaction with the community and lead to "the Primary Health Care Team" being added to Question 8c, so that it read: "Is the mother making excessive demands on the health visitor or primary health care team?".

The health visitors in the pilot study agreed that the main study should be longitudinal as they had noted postnatal depression developing several months after childbirth. Their feelings about a longitudinal study corroborated research evidence as to the timing of the onset of postnatal depression, and confirmed the wisdom of deciding on this design.

The pilot study indicated much enthusiasm for the project from mothers, midwives, health visitors and family practitioners.

Participant Observation, Checklists and Tape Recorders

The author felt some difficulty in deciding how much these research methods demanded piloting, for she was herself a health visitor in the district, of many years standing, and therefore well aware, of the possible content and practice of routine home visits, six months post-childbirth. However certain aspects needed piloting, especially the author's ability to be non-participant, and yet observant and objective, until the time when she became a participant observer; which in this study was only when the mothers' health visitors had completed the tasks of their visits.

The author kept a check list during the health visiting part of the visit (Appendix F), to be used as an aide memiore when she was participant observer. All the proceedings were tape recorded. Piloting these methods required considerable time, and needed to be tested with mothers who were in the study, during their early postnatal weeks. Therefore a decision was taken to test these three methods, during the visits of one health visitor to her 4 mothers, from the participant observation group.

Very little difficulty was found. The health visitors and the mothers accepted the researcher sitting and quietly observing the visit, and her use of the checklist and tape recorder; however the actual method of tape recording needed simple adjustments, particularly in the positioning of the microphone. The last point led to careful attention in the main study and is discussed further in the description of the method.

Client Diaries

At the end of the participant observation visits the author gave instructions to the mothers about completing the diaries. This, and the mothers' acceptance of receiving the diary were piloted. There was insufficient time to pilot the actual use of the diary adequately. Therefore the potential response rate was unknown.

Health Visitor Recording Schedule 2

This schedule was tested on 17 health visitors from the participant observation group. The author was actually present when these health visitors completed the schedule. Most had a little difficulty with the questions about the number of times the mothers had been contacted

during the year in clinics and home visits and for some health visitors this was almost impossible as the available records did not reflect when the mothers were in contact with "other" health visitors (these were health visitors who were not the health visitors responsible for the mothers care, and could have been met in clinics etc) Nonetheless this information was necessary in the study, and despite the difficulties, the questions were included in the main study. The health visitors did not express further problems, although the author had expected certain difficulties about question 12 - "Do you think this mother has had more than average health visiting?" (Appendix I).

Sending the schedules to the health visitors and assessing their response to completing and returning them was not piloted.

Mothers' Questionnaire

The mothers' questionnaire was piloted with the same four mothers used for the participation observation pilot study. This limitation was imposed by the longitudinal design, because those completing the mothers' questionnaire had to have been part of the study previously. It would have been preferable to use the same pilot group used for the Health Visitor Recording Schedule 1, however this was not pre-planned and it was impossible. The mothers were most co-operative during the pilot study and seemed to find the questionnaire simple to complete. Nevertheless it appeared appropriate to change the ordering of questions 8 and 9 (Appendix K).

Posting the questionnaire to the mothers was not piloted, and therefore, as with the client diary the potential response rate was unknown.

Family Practitioner Schedule

The Family Practitioners' Schedule was pre-tested in one group practice. No adjustments were necessary.

5.2. PERMISSION FOR UNDERTAKING THE STUDY, AND THE BRIEFING OF COLLABORATORS

Permission

Before beginning the study it was necessary for the proposal to be approved by various official bodies and for the author to be given permission to carry it out as she was an employee of the District Health Authority. Permission was duly obtained from Nursing and Health District Management and the Family Practitioner and Health District Ethical Committees.

Briefing of Collaborators

Discussions were held with the nursing management before commencement and at specific intervals during the 18 months to explain the study, and to foster approval and co-operation. It was also particularly important to obtain the continued co-operation of the health visitors who were to be largely responsible for administering psychometric tests, interviewing, and completing recording schedules, and in some cases they were also to be involved with tape recorded home visits with the participant-observer.

Prior to beginning the collection of information the author visited all midwives involved with the mothers in Sample One. She also attended meetings at the three community units in the health district, where she

met all the health visitors working in the district. During these visits the three broad categories of puerperal mental illness were outlined and the proposed project was discussed; the procedures for collecting information were explained in detail.

Open discussions were encouraged during these meetings in an attempt to resolve problems and reduce "experimenter bias".

During preliminary meetings the Director of Midwifery Services and the Directors of Nursing Services (Community) were consulted about the overall design of the research, and they with the Nursing Officers were kept informed of the progress of the study; nevertheless they were not responsible for any part of the management of the project, nor the collection of information. However the Director of Midwifery Services undertook to inform all midwives in the District (apart from those mentioned above and involved with sample I) that the study was taking place, and that they would be asked, by the health visitors, for their professional opinions about the likelihood of the mothers developing postnatal depression.

5.3. THE MAIN STUDY METHOD

In this section the actual procedures which were used when collecting information in the main study are discussed.

Only a few minutes were required to complete each test. This was an essential factor in maintaining the morale of both interviewers and the mothers during the months of the study, and therefore an aid in collecting high quality data.

Most of the tests had an accompanying letter containing instructions.

Confidentiality was assured by using two identification numbers in place of the mother's name on all the information and correspondence; one of these was the health visitor's number and the other could only be identified by the author using a complicated decoding system.

Pitt's Anxiety Test and the Crown-Crisp Experiential Index

Dr B Pitt, Consultant Psychiatrist, gave written permission for his test to be used in the main study. All the mothers in Sample I completed the test for the first time in the antenatal clinics, and for the second time at home during the home visit, 6 weeks post childbirth.

The Crown-Crisp Experiential Index was also completed by all Sample 1 mothers during the home visit mentioned above.

Health Visitor Recording Schedule I

Sample 2 Mothers

When the birth notifications were received by the district health computer section the information was forwarded to the health visitors, accompanied by a health visitor recording schedule, for each mother. These mothers made up Sample 2. Health visitors whose mothers had been selected for Sample 1 were not included in this procedure, they are discussed below.

As explained in the section on sampling methods in Chapter 4, this procedure was carried out by a number of clerks. The procedure was very simple and the clerks willingly helped and found no difficulty. They simply provided 4 schedules for each health visitor (1 short and 3 regular versions). When a birth was notified for a particular health visitor the schedule was sent out with the information - the short one first, and the 3 regulars with the next 3 consecutive births. The

clerks marked each schedule with 2 numbers, the health visitor's code number and a specific code number only decodable by the author.

The clerks also sent the health visitors a letter of instruction and a consent form with each schedule. The letter thanked the health visitors for participating and reminded them of points raised in the preliminary meetings. The consent form was a simple note for the mother covering ethical considerations; this included an explanation of the project, an assurance of confidentiality and an invitation to participate (Appendices B and C respectively).

The Health Visitor Recording Schedule reproduced as Appendix D has three parts, A, B and C; of these the last had two versions, regular or short.

Part A -

Most of the questions were about the mother's social history and ante-natal contacts. They could be completed by the health visitor from information she had received from the midwife and district community physician. Midwives normally care for a mother and her new baby for at least ten days and sometimes as long as twenty-eight days after childbirth. It is normal practice for a health visitor to visit the mother a few days after this period to observe the physical, mental and social condition of the family and advise on associated health needs. In the Portsmouth Health District the health visitors normally receive a copy of the "obstetric transfer report" at about the time of the primary visit; this is a summary, prepared by the midwife, of the mother's delivery and postnatal care .

As already mentioned, all the midwives in the district had been asked to report their opinion about the mother's feelings and the possibility of her developing postnatal depression , either verbally to

the health visitor, or in the obstetric transfer report.

Part B -

This portion could only be completed after the health visitor had made contact with the mother, at the primary visit; it required the health visitor's opinion about the possibility of the mother developing postnatal depression and her reasons.

Part C -

This section was completed by the health visitors during interviews with the mothers, six weeks after childbirth.

There were two versions of this section, the first 'Part C Short' had only one question which was about the possibility of the mother developing postnatal depression, whereas the second version 'Part C Regular' contained an extra nine questions which concerned Ritchie's (1977) subjective and objective items relating to the symptoms of postnatal depression.

The shorter version of Part C was used for the first of every health visitor's 4 mothers; the longer or regular version was used for the remaining 3 mothers as explained in Chapter 4.

It was hoped that the 2 different part C's in this system would indicate whether health visitors became more aware of the mothers' feelings if they actually asked the mothers questions about their feelings; as was necessary when completing the longer version of Part C. The regular version of Part C was an important part of the study, as even if a health visitor had had no previous education about emotional health related to childbearing, the questions in this section highlighted factors associated with postnatal depression, such as the

symptoms of the mother's appearance, or difficulties with sleeping, or irritability.

When the three parts A, B and C were completed the recording schedule was returned to the author.

Participant Observation and Tape Recordings

All the mothers in the participation observation group, and their health visitors, were observed during home visits 6 months post-childbirth.

Note was taken of the well known difficulties associated with the participant-observation method summarised by Jackson (1975) and efforts were made to minimise them.

Firstly, problems associated with note taking were largely avoided by tape-recording all the observed sessions in their entirety. However, this meant that there was no record of non-verbal communications.

All the health visitors and mothers (except one) gave permission for the use of the tape recorder and it appeared to create very few communication problems. Nevertheless there were three classes of difficulties using this method. First, to reduce distractions at the beginning of the interview, batteries rather than mains were used, and these needed regular replacement, sometimes in the middle of an interview; second, a suitable position had to be arranged for the tape recorder between all three parties (the health visitor, mother and author), out of reach of siblings and within easy control of the author, and finally there were "noises off" such as television and pet birds.

The second difficulty was the problem of the author remaining an independent observer when she, too, was a health visitor. It was

possible she overlooked the obvious, and may have over-identified with events being observed. Therefore, after initial introductions the observer was quiet and unobtrusive until the health visitor indicated the completion of her work for this "contact" and handed over the leadership of the interview. Then, using the aide-memoire, the author explored relevant points raised or omitted during the interview between the health visitor and mother.

The third difficulty was associated with the large quantity of valuable but often repetitious data; particularly as all the visits were concerned with the 6 month developmental checks of the babies. In this research information not connected with the mother's health was only collected in summary form. In Appendix O there is a transcript of one whole visit; however most of the other transcriptions did not include information about the babies' physical development, unless this had some bearing on the mothers' health. For example if the mother was very anxious about a feeding difficulty or a developmental delay this information would have been included, but, if the baby was developing normally and not giving the mother any concern the information was not included. Nevertheless it can be appreciated that the total volume of participant observation material was very considerable, and time-consuming to analyse.

This session was completed by discussing a further tool, the "Client Diary".

Client Diaries

The purpose of these diaries was to gather information from the mothers about when they felt depressed and what their needs were at these times. The mothers were invited to complete a small diary, and

the author made arrangements for its collection during the thirteenth month after the mother's confinement.

Each mother was given the diary, and a note (Appendix G) explaining the procedure and also absolving her from any obligation to maintain the diary, (this was thought necessary to maintain goodwill). They were asked to record the dates and times if they felt particularly anxious or depressed, how long the episode lasted and how they coped with these feelings.

Health Visitor's Recording Schedule 2 (HVRS 2)

The Health Visitor Recording Schedule 2 (Appendix I) was completed one year after the mother's confinement. The schedule was accompanied by instructions (Appendix H) advising the health visitor that it was unnecessary to make a special home visit before completion.

The first few questions were concerned with geographical movement of both the health visitors and mothers, because if a mother moved in most cases a new health visitor then took over the care.

In the health district there were recommendations and guidelines for contacts between the health visitors and mothers and relevant statistical information was collected. Nevertheless longitudinal studies about health visiting work are rare, and the present study offered an opportunity to note the contacts, of a large number of health visitors with four of their families during one year. These included the home visits, attendances at child health clinics or health visitors' health education groups, and occasionally contacts suggested by other people for example the family practitioners or social workers).

There was a question in this schedule which required a professional opinion based on the health visitor's experience and the facts about the

number of contacts. Most importantly "Do you think this mother has had more than average health visiting?" and when the answer was "Yes" the health visitors were expected to give the reasons why. Allied to this was the expectation that the health visitors would have got to know the mothers sufficiently well during the year to be able to say whether or not they had suffered from postnatal depression. In particular the health visitors would probably know when this had happened, with what symptoms and which community support systems had been available to the mothers.

These were important questions in the project, and followed on the discussions about puerperal mental illness that the author had had with the health visitors in the preliminary meetings before the study commenced; and also followed HVRS I (part C regular) which had many questions which referred to postnatal depression symptoms. The health visitors' professional opinion of the mothers' emotional health in the preceding year was sought. The author was able to collate these opinions with other health visitor opinions, such as the duration, and the symptoms, to arrive at a diagnosis of postnatal depression according to Pitt's 4 criteria.

For example, if the health visitor recorded that a mother had been depressed for 2 weeks or longer since her confinement, with at least two accompanying disabling symptoms, then these were considered to fit Pitt's 4 criteria for a postnatal depression diagnosis.

All the health visitors of the Participant Observation Group and Sample 1 mothers completed these schedules during pre-arranged visits from the author.

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Health Visitors' Records

Health visitors keep records of their health visiting care and these are the only routine basis of assessing what care a health visitor has actually given.

In this research the health visitors' records of the Participant Observation Group mothers and their children were scrutinised by the author when she visited the health visitors to complete the Health Visitor Recording Schedule 2. Only these records were scrutinised as all the other health visitors received their HVRS 2's in the internal mail system. This meant that additional arrangements would have been needed for the author to meet these health visitors, which would have been difficult because of the limited time available to the author and the health visitors.

Mother's Questionnaire (MQ)

In many cases the mother's questionnaire was posted to the mothers with an explanatory letter (Appendices K and J respectively). Upon completion, the questionnaire was returned in an accompanying stamped envelope.

All the sample 1 mothers completed a questionnaire during the routine home visit from their health visitors, one year post confinement. Prior to this the procedures were explained to health visitors concerned when they were visited by the author for the completion of HVRS 2. The participant observation group completed the MQ during a second interview with the author, this time at thirteen months post confinement; the "client diary" was collected during the same visit. The latter group of mothers were sent a letter reminding them of the interview date, and an opportunity to rearrange it if

necessary. If the mothers were out when visited, a second appointment was suggested, and if out on this occasion, the mother's questionnaire (MQ) and the Crown-Crisp Experiential Index (CCEI) were posted to her (as above).

Many questions in the MQ were similar to those found in the Health Visitor Recording Schedule 2 (HVRS 2); these questions also could be collated to equate a diagnosis of postnatal depression.

In the preparation of the questionnaire particular care was taken in the ordering of the questions (Moser & Kalton, 1971), with a gradual focus on the mother's feelings and the important relationships in her life, eg those with her own mother and her sexual partner. Focussing questions in a postal questionnaire can be rather difficult, because the questions may be read through before writing up, and anybody else in the family or home could complete them. This could have happened with this questionnaire. However, as nearly half the total sample of mothers completed the questionnaires during home visits, this likelihood was probably reduced. There was also an opportunity for the expression of additional feelings that might have been aroused by the nature of the questions, in the course of the inteview. For example, the questions referring to the maternal grandmother may have stirred up good or bad memories for the mothers. This appeared to have been so as many mothers recorded their memories in the spaces provided.

The order of the schedules was planned so that the health visitors completed the HVRS 2 before the mother completed the MQ. However it was possible that in some cases the health visitors and mothers conferred and provided similar answers. This possibility would have increased any concordance of the health visitors' and mothers' perceptions.

Family Practitioner Recording Schedule (FPRS)

The mother's health visitor delivered the Family Practitioner Recording Schedule (FPRS) to the relevant family practitioner, so as to facilitate completion and return (Appendices L, M and N).

The schedule was concise and asked two main questions: firstly, had the mother consulted the family practitioner during the past fifteen months, and secondly, did he or she think she had suffered from postnatal depression during this time.

5.4. SAMPLING RESPONSE

> "Survey response rates of above 85% are rare; more commonly in interview surveys they are about 75-80%. Postal surveys produce greater variations but should yield response levels of between 60-80%. In panel studies where the same people are asked questions on several occasions high response rates are unusual. The effects of geographical mobility, non-contacts and refusals are cumulative so that a 10% loss in the second or third rounds of the survey would result in an effective response rate of 65%." (Hoinville and Jowell, 1977.)

The present study was not strictly a panel study, because the number of potential respondents depended upon the real response to the previous stage of information collection, and the respondents in each case may have been different. For example, the Health Visitor Recording Schedule II (HVRS 2) was completed by health visitors, and was followed by mothers completing the Mothers' Questionnaire (MQ).

The sampling response in the present study was affected by the many personnel involved, the complex data collection methods, the mobile population and the long duration of the study. Therefore there was sample wastage, and it was fortunate that there were originally 386 mothers in the study.

Following up the non-respondents was difficult and hampered by time limitations. When an information collection instrument was not

TABLE 4

COMPOSITION OF SAMPLES

	ANTENATAL		POSTNATAL																
TIMES/ METHODS:	28 WEEKS PAT 1	CONFINEMENTS	2 WEEKS HVRS -1a,-1b	6 WEEKS -1cr	-1cs	PAT 2	CCEI 1	6 MONTHS P.O.	Ch.L.	Tapes	1 YEAR HVRS 2 (320*)	HV.Rec	13 MONTHS MQ (276*)	CCEI 2	CD	15 MONTHS FPRS (194*)			
SAMPLE 1	84		77	-	77	76	77	-	-	-		-		47	-				
SAMPLE 2 P.O.	-		309	225	84	-	-	61	61	60	294	58	235	56	24	161			
OTHERS	-					-	-	-	-	-		-		-	-				

CODE

PAT	Pitt's Anxiety Test
HVRS	Health Visitor Recording Schedule
1cr	Regular Version of HVRS Section 1c
1cs	Shortened Version of HVRS Section 1c
CCEI	Crown Crisp Experiential Index
P.O.	Participant Observation
Ch.L.	Check Lists
HV.Rec	Health Visitor Record
M.Q.	Mothers Questionnaire
CD	Client Diary
FPRS	Family Practitioner Recording Schedule
*	The total number of Questionnaires issued

completed either by a health care worker, or the mother, no further information was collected for this mother. Thus if the HVRS 2 was not completed, the mother concerned was not asked to complete the MQ. There were two reasons for this: (a) the non-completion could be due to a change of health visitor, or movement of the mother, and (b) it was possible that the mother had declined to continue participating in the study.

These points are illustrated in Table 4, which shows when the information was collected and the potential and actual response for each collection method.

Sample Response six weeks after Childbirth

This section discusses the response of the two samples of mothers and the health visitors during the first few weeks of the study.

Sample 1

The midwives had been asked to invite the co-operation of every mother who was eligible (refer to sampling methods in the previous chapter) and to note all refusals. No refusals were noted, yet it is unclear whether every mother was invited. It is suspected that midwives may, without being aware of it themselves, not have invited mothers who were already rather anxious about their pregnancy.

Although 84 mothers completed Pitt's Anxiety Test 1 within the time allowed, seven mothers were 'lost' for administrative reasons before completing the test again; this was simply because the midwife did not always inform the relevant health visitors, that the particular mother was in the survey.

As shown in Table 4 there were complete sets of data for 77 mothers

in Sample 1, six weeks after childbirth (ie Pitt's Anxiety Test 1 and 2* (PAT 1 and 2), the Crown-Crisp Experiential Index 1 (CCEI 1) and a Health Visitor Recording Schedule 1 - short version (HVRS 1 - short).

* One mother felt too depressed to complete PAT 2.

Sample 2

The author believes that the computer section sent 338 HVRS I to health visitors; 309 were completed and returned making up Sample 2. It is known that of the 29 not returned 10 mothers declined to participate, and 11 more were not invited to do so by their health visitor. On most occasions the mothers' were not invited because their health visitors were on 'sick leave', and it was difficult for the relief health visitor to manage the extra work demanded by the study. A further six mothers delivered twins, and although a schedule was allocated for each birth only one per mother was required. Two mothers whose babies were adopted were also not included in the study. The HVRS 1 (short) was completed by 84 mothers and made up sample 2a, whereas 225 mothers completed HVRS II (regular) making up sample 2b.

The HVRS 1's were sent to the health visitors with their routine information about the birth from the district community physician. This was accomplished with considerable co-operation by the staff in the Immunisation and Vaccination Section of the Health District. Great care was taken to record all HVRS 1 distributed. However, with the size of the district, there was at times inevitably some uncertainty about which health visitor was responsible for a mother. Therefore it is not entirely certain that all distributed HVRS 1's were returned, although most seem to have been. Also as health visitors were not obliged to participate in the project, it is possible that one or two declined to

do so, and because of the above-mentioned difficulties, they may not have been accounted for.

Response Rate to Participant Observation at Six Months

The health visitors randomly selected for the participant observation group were all invited and agreed to be involved in the Participant Observation of their routine home visits occurring six months after childbirth. The mothers were then invited by their health visitor either by telephone, during a visit or by letter, to take part in the observed visit, and an appointment was made.

Three of the 64 mothers were not observed at six months. One mother declined, because she was unwell, and one mother was not asked to participate by the health visitor as their relationship had been rather strained. The third mother had forgotten the appointment and was out, but she later asked to be kept in the study. All other six-month interviews took place as arranged.

Check lists were kept during the visits to the 61 mothers. Only one mother declined to have the observed visit tape recorded. All mothers visited and the mother who forgot the interview, but who stayed in the study, accepted a client diary.

Response Rate for Health Visitor Recording Schedule 2 (HVRS 2)

Although the original HVRS 1 had been completed by 386 health visitors, at the 12-month follow-up stage only 320 HVRS 2's were sent out. This was because:

30 mothers had moved (these were identified during the decoding process in the District Computer Section),

36 HVRS 1 had not been completed sufficiently thoroughly which meant that comparisons were impossible and identification rather difficult.

Of the 320 only 294 (91%) were in fact returned, losses being due to the following causes:

3 Health visitors did not return the schedule nor give reasons for non-completion,

23 health visitors failed to make contact with the mothers because the health visitor was too busy or off sick; there were instances where recently appointed health visitors did not know the mothers concerned. A few health visitors were untraceable (however with more clerical assistance this might have been possible).

Ten schedules that were returned were not completed. These families had also moved out of the district.

Response Rate to Mother's Questionnaire (MQ)

The Mother's Questionnaire was only sent to 276 mothers although HVRS 2's were completed for 294 mothers; eight mothers were not followed up at the request of the health visitor concerned, and another six because the HVRS 2 was not returned by the health visitor within the time allowed. The response rate was 85.1% as 235 out of the 276 questionnaires were completed and returned. Due to lack of funding and time those mothers who did not complete and return their questionnaires were not contacted again. The author regrets having had to make this decision, as despite the adequate response rate noted above she believes it would have been even better if the mothers had been sent a reminder or second request. This was indicated by the positive reponse to home visits mentioned in the following paragraphs.

The participation observation group were included in the above numbers, but they are mentioned here separately to illustrate their response rate:

Four of the 62 mothers were no longer eligible as they had moved out of the district.

Fifty two out of 58 mothers completed the questionnaire during a home visit. Six mothers failed to keep the home visit appointment with the researcher, four of these responded when sent a postal questionnaire, two did not.

Thus 96.6% (56 out of 58) of the mothers in this group eligible to complete the questionnaire did so.

The health visitor records for all 58 mothers mentioned above were scrutinised by the author to find recorded information about the mothers' health visiting care.

Response Rate to Crown-Crisp Experiential Index 2 (CCEI 2)

All 48 mothers remaining in the study in Sample 1, the 51 mothers visited and the 4 mothers sent a postal questionnaire, in the participant observation group, completed the Crown-Crisp Experiential Index 2 (one mother visited declined to complete the questionnaire).

Response Rate to the Client Diary

Sixty two mothers visited at 6 months were invited to keep the diary. Fifty six of these were contacted and could have returned the client diary; only 24 mothers did so, or 43%. The reasons the mothers gave for not returning the diary included failing to write it up and losing it.

As already mentioned this method was not piloted and therefore a

possible response rate was unknown. Also, as mentioned earlier in this chapter, the mothers were told that they were under no obligation to complete, and that the researcher would return to see them at the end of the year, whether they kept the diary, or not. A young mother is very busy, and is very tired when she does have a little spare time, therefore a good response was not expected. Maybe also depression would have reduced the likelihood of making the effort to complete the diary.

Response Rate to the Family Practitioner Recording Schedule (FPRS)

Family Practitioner Recording Schedules were sent to 194 health visitors to arrange for their completion by the Family Practitioner. Thirty-one schedules were not sent to avoid health visitors on sick leave and where completion difficulties were expected; as shown in Table 4, 161 FPRS were returned, or 79%.

Non-completion of this schedule usually occurred where health visitors had difficulties liaising with the family practitioner. In most cases this was where the health visitors' offices were not close to those of the family practitioners; secondly, health visitors reported that one or two family practitioners had refused to participate; and thirdly, there were mothers who were apparently not registered with the family practitioner, although this was contrary to the author's information.

5.5. AGE, MARITAL STATUS, AND SOCIAL CLASS OF MOTHERS IN SAMPLES 1 AND 2

Age and Marital Status

In the study 58 mothers (15%) were under 21 years of age and the average age was 25 years, as shown in Table 5.

TABLE 5

AGE OF MOTHERS IN SAMPLES 1 AND 2 COMBINED

	Mothers	
Age in Years	No.	%
15-20	58	15
21-25	130	34
26-30	128	33
31-35	56	14
36-40	12	3
Over 40	2	1
Total Mothers	386	100

Mean: 25 years

Standard Deviation: 5.535

Table 6 shows that 358 out of the total 386 mothers (93%) were married, another 22 mothers (6%) were cohabiting and six mothers (1%) lived alone without a partner.

TABLE 6

MARITAL STATUS OF MOTHERS IN SAMPLES 1 AND 2 COMBINED

	Mothers	
Marital Status	No.	%
Married	358	93
Co-habiting	22	6
Living alone	6	1
Total Mothers	386	100

Social Class

The women in the study were categorised according to the social class of their sexual partner. The men were classified according to the Registrar General's Classification:

1. Professional.
2. Intermediate occupations (including most managerial and senior administrative occupations).

3N. Skilled occupations (non-manual).

3M. Skilled occupations (manual).

4. Partly skilled occupations.
5. Unskilled occupations.

Unclassified. These include the armed forces, students and those whose occupation was inadequately classified.

In the present study there were many members of the armed forces, both Army and Navy; generally these occupations were only recorded as 'navy' or 'army' on the health visitor recording schedules, without noting differences for example between able seamen or officers. If differences were noted they were categorised separately in Table 7; those labelled as 'navy or army' were classified as Social Class 7; similarly those called 'officers' were categorised as Social Class 6. However in Table 8 officers have been included in the Social Class category 2 and 'navy or army' in Social Class category 4.

TABLE 7

SOCIAL CLASS OF MOTHERS IN SAMPLE ACCORDING TO PARTNER'S OCCUPATION (SERVICES CATEGORISED SEPARATELY)

(Registrar General's classification)

	Mothers	
Social Class	No.	%
1	29	8
2	36	9
3 (N)	49	13
3 (M)	74	19
4	69	18
5	17	3
Unclassified*	38	9
6 Officers	6	>1
7 Army/Navy	68	18
Total Mothers	386	100

*There was inadequate information to classify these mothers.

TABLE 8

SOCIAL CLASS OF MOTHERS IN SAMPLE ACCORDING TO PARTNER'S OCCUPATION*

(Registrar General's Classification)

	Mothers	
Social Class	No.	%
1	29	8
2	42	11
3 (N)	49	13
3 (M)	74	19
4	137	35
5	17	4
Unclassified	38	9
Total Mothers	386	100

* 'Officers' have been included in Social Class 2.

'Army/Navy' have been included in Social Class 4.

TABLE 9

THE SOCIAL CLASS DISTRIBUTION IN SAMPLES 1, 2a AND 2b

Social Class	Sample 1	Sample 2a	Sample 2b	Total
1	6	9	14	29
2	1(3)	9(10)	26(29)	(42)36
3N	4	7	38	49
3M	8	10	56	74
4	10(47)	26(34)	33(56)	(137)69
5	5	2	10	17
6	2	1	3	6
7	37	8	23	68
Unclassified	4	11	23	38
Total	77	84	225	386

All the numbers in parenthesis are the corrected totals when adding the army and naval officers (social class 6) to social class 2, and all other army and naval occupations (social class 7) to social class 4.

Table 10 illustrates the social class of the mothers in the different age groups. The ages ranged from under 16 years to over 41 years with the cluster for all social classes around the ages of 20 - 35 years. There was a major difference in the ages of mothers in Social Class 4 and all other classes. For example there were 26 (19%) out of 137 mothers (including "navy") in the combined age categories of 16 - 21 years and under 16 years compared with 12 (10%) out of 123 mothers in Social Classes 3n and 3m (together); there were few mothers of 20 years and under in any other Social Class category.

TABLE 10

THE SOCIAL CLASS OF THE MOTHERS BY THE MOTHERS' AGE
(ACCORDING TO PARTNER'S OCCUPATION)

(Registrar General's Classification)

Social Class	Age <16	16-20	21-25	26-30	31-35	36-40	41+	Total
1	0	1	3	16	8	0	1	29
2	0	1	9(12)	12(14)	12(13)	1	1	36(42)
3N	0	4	13	17	12	3	0	49
3M	0	8	27	31	7	1	0	74
4	1(3)	13(23)	28(56)	18(39)	4(11)	5	0	69(137)
5	0	5	8	4	0	0	0	17
6	0	0	3	2	1	0	0	6
7	2	10	28	21	7	0	0	68
Unclassified	1	12	11	9	5	2	0	38
Total Mothers	4	54	130	128	56	12	2	386

The numbers in parenthesis are the corrected totals when Service officers (social class 6) are added to social class 2, and all other Service occupations (social class 7) to social class 4.

The differences between the Social Class distribution in Samples 1 and 2

Sample 1 was collected by sampling mothers in the antenatal clinics of chosen general practitioners. These general practitioners were selected carefully as they had practices including patients from all the different social classes in Portsmouth Health District. The two practices in Gosport included patients in the large Rowner naval estate

and the practices in Portsmouth City included patients living in bed-sitting accommodation. One of the reasons for choosing the Gosport practices was ease of access for the researcher and another was the relatively high birth rate, which enabled fairly rapid sampling. However the high birth rate appears to have been concentrated amongst naval families and affected the social class distribution, shown in Table 9. A chi-square test showed the difference between the samples as $X^2 = 95.64$, for 16 degrees of freedom ($p < .001$). The difference was especially due to the large number of social class 7 (navy) in Sample 1.

When the navy were recoded as social class 2 for naval officers, and social class 4 for all other naval families, the chi-square test still showed a difference, $X^2 = 53.56$ for 12 degrees of freedom ($p < .001$). On this occasion the difference was chiefly due to social class 4 (including navy). These differences will be mentioned again when discussing the results.

5.6. THE DIFFERENCES BETWEEN THOSE MOTHERS WHO COMPLETED THE TESTS AND THOSE WHO DID NOT

Two hundred and eighty four HVRS 2 schedules were returned completed; the social classes of the partners of these 284 mothers were compared with those of the partners of the 102 mothers 'lost' from the original total of 386 mothers. A chi-square test resulted in $X^2_8 = 7.74$ not significant ($p > .10$). Similar comparisons were made for the 235 mothers who completed the MQ and the 59 mothers making up the total of 294 returned HVRS 2's (including 10 HVRS's returned, but not completed as families had moved). This time a chi-squared test showed $X^2_8 = 12.94$ also not significant ($p > .10$). This was despite an interesting difference amongst the mothers whose partners were unclassified, or

where the mother had no partner; the comparison showed that 43.5% of the mothers in this social class (10 mothers compared to 13 mothers in the other group) did not complete the MQ. This was a much higher percentage than for any other Social Class group.

Another test was done to establish whether there was a difference between those mothers who had dropped out and those who had not; a t-test was done between two groups of sample 1, the first group consisting of the mothers who had completed both CCEI 1 and 2 (under the heading "anxiety and depression") and PAT 1 and 2, and the second consisting of the mothers who had not completed CCEI 2. There was no significant difference between the mean scores of the CCEI 1 (sub-scales: anxiety and depression) of the two sets of mothers ($p > .20$).

Also, to establish whether there was a difference between those mothers in sample 1 and sample 2 (participant observation group) who completed CCEI 2, a t-test was done between these two groups. No significant difference was revealed between the mean scores of CCEI 2 (sub-scales: anxiety and depression) for the two groups ($p > .20$).

No significant difference was found in sample 1 mothers who only completed tests at six weeks and those who completed tests one year later (see above), and similarly, no significant difference was found with sample 1 and the participant observation group mothers completing tests at a year (see paragraph above). It was therefore assumed that as the participant observation group was a random sample of sample 2, there would also be no significant difference between mothers in sample 1 and sample 2.

5.7. PREPARING THE DATA FOR ANALYSIS

Perhaps it is of value to repeat that the organisation of this longitudinal study was a difficult task. All the operations were sequential. The forms on which the information was recorded were numbered and then completed, and returned to the researcher within an allotted time.

When this had been done the information required further attention before beginning the analysis, and was done by two methods as follows:

1. The recording schedules, questionnaires and psychometric tests were all coded (Silvey, 1975) in preparation for using the Southampton University ICL 2970 Computer and the Statistical Programme for Social Sciences, known as SPSS.

A copy of the method of encoding the data is included in Appendix P. The coding was done by the researcher and a clerk, and it was necessary to establish that their coding was similar. Therefore a coder reliability test was done; both coders coded the same 20 randomly sampled schedules, independently. Their coding errors were recorded and compared; the percentage error was 0.21% showing a high degree of concordance.

One example of the computer programmes used in the present study is also in Appendix P. This programme provided the information which was the basis of the discussion about depressive symptoms in Chapter 6.

2. The tape recordings of the participant observation visits were transcribed by a skilled dictaphone typist, who was well briefed by the author. Thereafter the contents were categorised manually by the author, as were the contents of the client diaries.

CHAPTER 6

DEPRESSED MOTHERS

The analysis of the information collected in the main study will be discussed in 3 parts:

The first part is a description of mothers with excessive postnatal anxiety or postnatal depression after childbirth, and is in this chapter. The mothers' own descriptions of their feelings which they noted in their client diaries and how they coped are described in Chapter 7. The associated health care, especially health visiting care is described in Chapter 8.

Definitions of the statistical terms in the text are included in the glossary.

6.1. INTRODUCTION

The description of excessively anxious or depressed postpartum mothers commences, in Section 6.2, with identification of those mothers who said they had felt this way (this could also be called the mothers' expressed needs). Then, there follows the mothers' description of the duration of their depression, as well as when they thought it had begun and when they had recovered. This is followed by a description of their other associated depressive symptoms. The mothers' opinions were tested against Pitt's 4 criteria for determining the presence of postnatal depression.

The discussion in Section 6.3 describes other opinions about which mothers were depressed; namely the clinical opinions of the family practitioners, the professional opinions of health visitors, and the

diagnoses determined by psychiatric screening tests (these could be termed the normative needs). Finally, reasons for choosing the mothers' opinions as the basis of the further analyses are explained.

Factors possibly predicting excessive postnatal anxiety or postnatal depression are discussed in Section 6.4. Similarly psychosocial factors associated with the postnatal depression are noted in Section 6.5.

In the last section, 6.6, there is a discussion about those persons in the mothers' community network system who were available to help them when they had their babies.

6.2. MOTHERS' OPINIONS ABOUT THEIR DEPRESSION

It was shown in Chapter 5, Table 4 that a total of 235 mothers completed questionnaires thirteen months after childbirth; 131 (55%) of these mothers said they had had periods during the year when they felt excessively anxious or depressed, these are shown in Table 11. (The 235 mothers included mothers from both samples 1 and 2 which were described in Chapter 5.)

It will be seen from Table 11 that the 131 mothers admitted to feeling depressed on at least some days during the first 13 months after childbirth. However 21 of these (9% of the 235) did so for only a few days. Attention will be concentrated on the 110 mothers who experienced depression for at least two weeks (110 of 235 mothers, or 47%*).

*Footnote: This figure of 47% would range from 35-59% with a 95% confidence interval (the statistical terms used in this study are explained in the Glossary).

symptoms and mentioned at least two of the following: tiredness, irritability, tears, feeling very different from normal, sleep difficulties, weight changes and other problems, including feelings of being unable to cope, aggression and a decrease in sexual libido. These are shown in Tables 12 and 13.

TABLE 12

SYMPTOMS DESCRIBED BY 110 MOTHERS
WHO FELT DEPRESSED FOR LONGER THAN TWO WEEKS

Mother's Opinion	Mothers	
		%
Depression and/or excessive anxiety	110	100
Tiredness	81	74
Irritability	77	70
Tears	73	67
Feeling very different from normal	60	55
Sleep	44	40
Weight	33	30
Other problems*	60	55
Total Symptoms	538	
Total Mothers	110	

Average symptoms/mother = 4.9

* Other problems are categorised in Table 13

Source: Mothers' Questionnaire

The mothers were free to list as many symptoms as they wished.

TABLE 11

MOTHERS' OPINIONS ABOUT THEIR DEPRESSION DURATIONS

Mother's Opinion	Mothers	%
No depression	94	40
Uncertain	10	4
Depressed for less than two weeks	21	9
Depressed for two weeks or more	110	47
Total Mothers	235	100

Source: Mothers' Questionnaire

Depressive Symptoms described by Mothers

As discussed in Chapter 2, many researchers (such as Pitt, 1968; Snaith, 1982; Cox, Connor & Kendell, 1982, etc) have noted differences between the symptoms of postnatal depression and general neurotic depression. The core symptoms of general neurotic depression (fatigue, insomnia and loss of libido) are usually present in postnatal depression, but overshadowed by other symptoms, especially anxiety and irritability (Snaith, 1982). Pitt (1968) noted especially that the insomnia pattern for postnatally depressed mothers was difficulty in getting to sleep, the opposite to the early wakening of classical depression. Generally, postnatally depressed mothers report no delusions, hallucinations or serious suicidal thoughts (Cox, Connor & Kendell, 1982).

All mothers in the present study who described depressive feelings or excessive anxiety lasting more than two weeks had an average of five

The Mothers' Questionnaire (MQ) was completed by 235 mothers; 135 of these mothers received the MQ by post; the other 100 mothers completed the MQ during an interview with the author in their homes. It is likely that if more home interviews had been undertaken additional mothers with symptoms would have been noted. Certain known symptoms of postnatal depression such as a decrease in sexual desire or feelings of inadequacy were not specifically asked about; because they might have aroused further anxiety they were not considered to be suitable for a postal questionnaire. However it will be noted from Table 13 that references to them were introduced in the Mothers' Questionnaire (MQ) by the mothers themselves.

All 110 mothers mentioned the symptom of depression and/or excessive anxiety, 81 mothers (74%) described tiredness, and 70 mothers (70%) irritability. Excessive crying and feeling very different from normal were each mentioned by over half the 110 mothers. These were similar to the specific symptoms isolated by other researchers, as noted above (Pitt 1968; Snaith 1982; Cox, Connor & Kendell 1982).

*Footnote: A copy of the computer programme and ouput which provided the information for Tables 12 and 13 has been included in Appendix P.

TABLE 13

PRINCIPAL OTHER PROBLEM* DESCRIBED BY 110 MOTHERS DEPRESSED FOR LONGER THAN TWO WEEKS

Symptom	Mothers	%
Illness or infection	15	14
Abnormal anxiety	12	11
Unable to cope and feelings of inadequacy	12	11
Feelings of isolation and agorophobia	7	6
Aggression and irrational behaviour towards children	6	6
Decrease in sexual libido	5	5
Feelings of total submergence in motherhood	3	3
Total Mothers	60	56

* Only one principal additional symptom or problem per mother was included in this table.

Source: Mothers' Questionnaire

Three mothers' own descriptions of their symptoms are given below:

One mother who had felt depressed for a whole year and which was recognised by her health visitor and family practitioner said:

> "Throughout my experience I thought I was going mad and would never lead a normal life again. I found out about postnatal depression by reading about it in a magazine. It would have been very helpful if I had had a leaflet or known some other mother going through the experience. I lost over a stone without dieting. I felt constantly tired and wanted to sleep all the time. I felt very tearful and cried over anything. I was in a state of constant panic, terrified of leaving the house and of being in it. I felt as if I was in a tunnel with no light at the end."

A second mother whose depression was not noted by the professionals

said:

> "I was depressed for much of the first six months after my daughter was born. I felt exhausted all the time. All my family live a long way away - so I had no ready help. I was always bursting into tears and felt that I could not cope. I felt irritable and irrational unexpectedly. I felt very different from my normal self. There were so many problems."

Another said:

> "I had difficulty getting to sleep despite being very tired. I cried easily and did not know why. I felt very different from normal and quite vague. I didn't really know what I was doing here. I felt totally disinterested in sex, anyway I was too tired."

Criteria for Defining the Presence of Postnatal Depression

In 1968 Pitt, a psychiatrist, carefully listed the criteria he used to define the presence of postnatal depression, and he is one of the few researchers to have done so; Kumar (1982) suggested that Pitt's definition should be the main standard against which to compare other investigations. Cox, Connor & Kendell (1982) used Pitt's definition and criteria to estimate postnatal depression in their sample of mothers 3-5 months postpartum; using this method they diagnosed 13% severely depressed and a further 16% less depressed.

Pitt's definition was also used in the current study, and his four criteria are restated below:

1. Subjects should describe depressive symptoms;
2. these symptoms should have developed since delivery;
3. they should be unusual in their experience and to some extent disabling; and
4. the symptoms should have persisted for at least two weeks.

The last point was paramount as Pitt believed it took at least two weeks to adjust to the new baby. However it should be noted that in his own study he used these four criteria to diagnose postnatal depression

at six to eight weeks after childbirth, during an interview, and again at one year postpartum, the latter by postal enquiry. Cox, Connor and Kendell (1982) used these criteria to estimate depression up to three to five months postpartum, whereas in the present study it was used to estimate depression for the whole postnatal year.

It will be seen that the mothers who responded to the current survey by describing experiences of depression did so in terms which satisfied Pitt's Criteria, namely:

1. 110 mothers described depressive symptoms.

2. These symptoms had developed since the birth of the baby.

3. The symptoms were unusual enough in the mothers' experience, for them to be mentioned. However it is difficult to assess the disabling effect of the symptoms (as who should make this decision - the mother, the carer or the researcher?). The author believed that excessive tiredness, irritability, tears, or indeed any of the symptoms mentioned could have disrupted the mothers' normal relationships and their coping abilities. Therefore in Pitt's terms these symptoms could have had a disabling effect.

4. The symptoms persisted for at least 2 weeks for 110 mothers.

It therefore seems reasonable to regard this group of 110 mothers as suffering from postnatal depression, and hereafter they will be termed the depressed group.

This number of 110 mothers (47% of 235) suggests a higher incidence of postnatal depression than previously recorded by other researchers (Pitt, 1968; Cox, Connor & Kendell, 1982 and Kumar & Robson, 1982). However all other studies screened the mothers at specific intervals, such as three-monthly (Kumar & Robson, 1982), and may thus have missed some mothers who had significant periods of depression in the interim.

The figures in the present study appear at first to be higher than the 15% (17 out of 114 mothers) found depressed by Kumar and Robson (1982, p50) and 13% (13 out of 103 mothers) found by Cox, Connor and Kendell (1982). The differences diminish on further examination, as follows. Kumar and Robson's main sample were all primiparous and were tested once pre-conceptually, three times antenatally and four times postpartum. Kumar and Robson thought that the antenatal contact had possibly reduced the incidence of postnatal depression especially when they compared the results of the above sample with another of their samples of 79 mothers (a combination of multiparous and primiparous women); in the latter sample 22 (28%) women were found to be postnatally depressed, although it is not clear when in the postnatal year these measurements were taken, but it was probably within the first three to five postnatal months. Similarly in another study Cox, Connor and Kendell (1982) described 13 of 103 mothers (13%) who fulfilled Pitt's Criteria for postnatal depression and a further 17 mothers (16%) whose depression had remitted by the time of testing (three to five months postpartum) but nonetheless had had a depression lasting for at least four weeks since childbirth. Watson (1984) identified affective disorder in 15 out of 128 women (12%) at the sixth postnatal week and a further 13 mothers were identified as having had an affective disorder at some time during the postnatal year; therefore a total of 28 (22%) out of 128 mothers had an affective disorder during the postnatal year.

The results found in the present study were slightly higher than the above studies although it was not possible to make direct comparisons; in the present study there were 64 cases (27%) of postnatal depression up to six to eight weeks postpartum, and after this a further 25 cases (11%) up to six months .

It is not obvious whether Kumar and Robson's (1982) sample of mothers were assessed as postnatally depressed from the results of a semi-structured clinical interview schedule, or by a psychiatrist's assessment. Cox, Connor and Kendell used the same semi-structured interview schedule as Kumar and Robson did, but they adapted it. Nevertheless it appears that instead of using the results they obtained on this psychiatric screening schedule Cox et al used Pitt's four criteria, for their decisions about the postnatal depression incidence. However it was not clear whose opinions about the mothers' depressive state were used to fulfill Pitt's four criteria for postnatal depression, whereas in the present study the mothers' own opinions were accepted without depending on another person for selecting the material. Therefore in the present study it was possible that a number of mothers may have exaggerated, or minimised, the duration and symptoms of their depression when they recorded the information at the end of the postnatal year.

The Severity of the Depression

In the present study no differentiation was made between seriously depressed and less depressed mothers. One reason for this was the difficulty of choosing appropriate tests for identifying the postnatal depression, as described in Chapter 4, even without considering the severity.

The mothers' own interpretations of their depressed feelings were assumed to be as important as someone else's measurement of the intensity. Therefore if mothers had felt sufficiently depressed to have remembered and recorded their feelings, then these mothers had probably deserved attention from the health carers; particularly when the

depressed feelings lasted for some time.

When the Depressive Period Started

It would be useful for the health carers if they knew when in the postnatal year mothers may become depressed. Table 14 shows the incidence (new cases) and prevalence (total number of cases) of postnatal depression, during three phases of the year.

The first phase was up to two months, covering the mothers' normal six to eight week postnatal appointment with her family practitioner. This was also the period at which Pitt (1968) diagnosed postnatal depression in 10.8% of his sample of 303 women. The second phase in Table 14 was between two and six months after childbirth; although Pitt did not consider this stage many studies on postnatal depression have done so (Breen, 1975; Kumar and Robson, 1982, and Cox, Connor and Kendell, 1982). However, the third phase continued until the end of the year, and has less often been included in postnatal depression research investigations.

It can be seen in Table 14 that the time of onset of the depressive period varied considerably. Sixty four (58%) of the 110 depressed group of mothers became depressed within the first eight weeks. There were 25 new cases (23% of 110 mothers) between two to six months, and another 21 new cases (19% of 110) in the second six months of the year.

Kumar (1982) described his prospective survey which was carried out on 119 primiparae in the first, second and third trimesters of pregnancy, and then at intervals during the postnatal year; retrospective information was also obtained about any psychiatric problems in the three months preceding conception. Kumar's sample was skewed towards a group of higher economic status, all the mothers were

married or stably cohabiting, they all spoke good English, and were all having their first baby. His findings showed a sharp rise in depression in the first three months of pregnancy and again in the first three months post-childbirth. All these women were interviewed by a psychiatrist, using a standardised method at 12 weeks antenatally, and again at 12 and 52 weeks postnatally. The subjects were also seen by a psychologist at three intervals in pregnancy and again at one, 12, 26 and 52 weeks postnatally. There was a wastage of a few mothers at each test time.

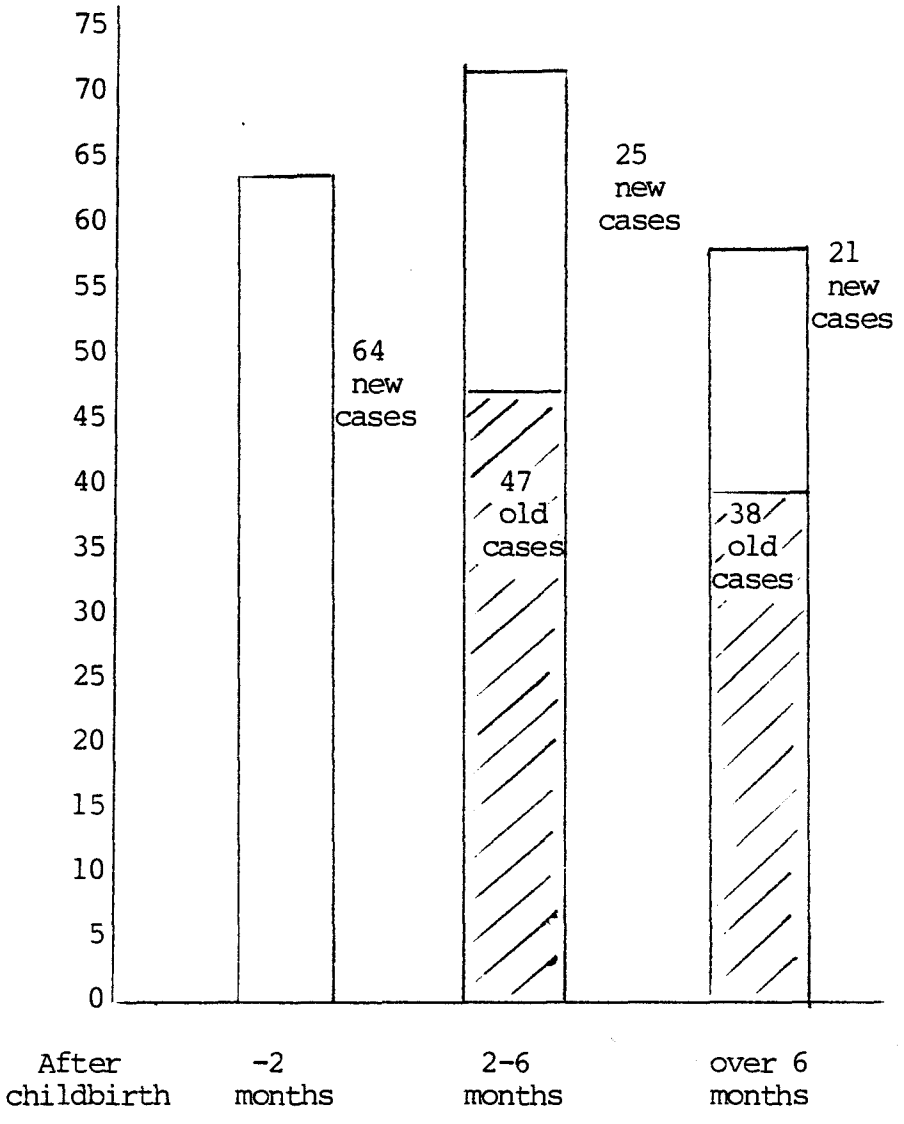
TABLE 14

THE INCIDENCE AND PREVALENCE OF POSTNATAL DEPRESSION

Total n = 110 depressed mothers (235 mothers in the sample)

□ = new cases from previous stage to this stage

▨ = cases persisting from the previous stage

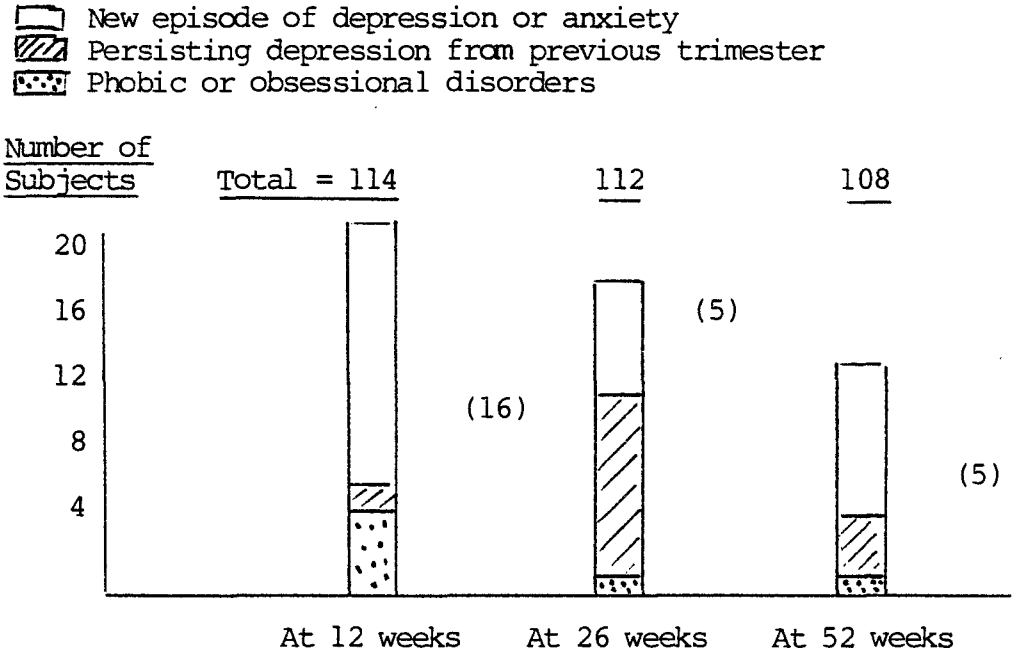


Source: Mothers' Questionnaire

Table 15 below illustrates Kumar's findings; the table shows new episodes of depression, at specific times post-delivery, as well as those depressions that had persisted from the previous trimester. For example, at 12 weeks 114 mothers were in the survey (five of the 119 had dropped out), there were 13 (11%) new cases of depression and four depressions that had continued since pregnancy. At 26 weeks there were another five (4%) new cases out of 112 mothers (a wastage of two more mothers) and by the end of the year there were 108 mothers left in the survey, amongst these mothers there were five new cases of postnatal depression. These 26 new cases of depression post-childbirth appear to be at least 22% of the original sample of 119 mothers (12% was mentioned in Kumar's paper). In Kumar's table the first postnatal measurement was at 12 weeks, and showed 16 new cases of depression; the author's first period of measurement in Table 14 was up to eight weeks post-childbirth, and showed a total of 64 cases (27% of 235 mothers) of postnatal depression; it seems as thought Kumar's first postnatal measurement of 16 new cases out of 114 mothers (14%) at 12 weeks may have missed many earlier depressive episodes especially if they had resolved by the time of the test. The next measurement period in the author's study included Kumar's 12-week test time and continued until his next at 26 weeks; Kumar identified five new cases (4%) at this time and also showed that a large number of mothers had remained depressed since the previous test time; in the author's study, during the two to six-month postnatal period, 25 new cases of postnatal depression were identified (11% of 235) and 47 (20% of 235) other mothers had remained depressed.

TABLE 15

KUMAR'S NEW EPISODES OF DEPRESSION AND/OR ANXIETY, POSTNATALLY



Source: Kumar, 1982, p99, part of Figure 2.

The numbers in parentheses are the new cases of depression.

These two tables suggest that both Kumar's and the author's method of measurement revealed a high incidence of postnatal depression in the first six postnatal months, and that for many mothers, the depression continued for several weeks. The author's third measurement period during the second half of the postnatal year was compared with Kumar's measurement at the end of the year; during the second half of the year the author found 21 new cases, 38 old cases, and, interestingly, at the end of the year 22 mothers (9% of 235) were still depressed. At the one-year measurement in Kumar's study there were five new cases (6% of 108 mothers), and at least two mothers who had remained depressed since the 26th postpartum week. Despite the different periods of measurement both studies show the high incidence of postnatal depression in the

first few weeks postpartum, but equally importantly they also both show that new cases developed throughout the year, and that the depression persisted for long periods, for many mothers.

The stage at which the depression began was used in a number of cross tabulations in the present study, and was particularly useful for comparisons with the screening tests completed within the first two postpartum months and described in Section 6.3.

Duration of Depression

The duration of the mothers' depression is shown in Table 16. The largest single group of the depressed mothers comprised the 48 mothers (20% of 235 mothers) in the two to eight weeks category, but a rather larger proportion of 72 mothers (26% of 110 mothers) were depressed for longer than this. Indeed 28 mothers (12% of 110 mothers) were depressed for more than six months, and in such cases, where the onset was comparatively late, say at six months after childbirth, the mother would still have been depressed at the end of the research period at 13 months. Six per cent (15 mothers) actually maintained their depressive experiences had lasted the whole of the follow-up period (12 to 13 months).

TABLE 16

MOTHERS' OPINIONS ABOUT THE DURATION OF THEIR DEPRESSION

Mothers' Opinion	Mothers	%		
No depression	94	40		
Unsure whether depressed	10	4		
Depressed less than 2 weeks	21	9		
Depressed from 2 to 8 weeks	48	20		
Depressed over 8 weeks to 6 months	34	14	110	47%
Depressed over 6 months to 13 months	28	12		
Total Mothers	235	100		

Source: Mothers' Questionnaire

All the information presented in Table 11 is included in the above Table.

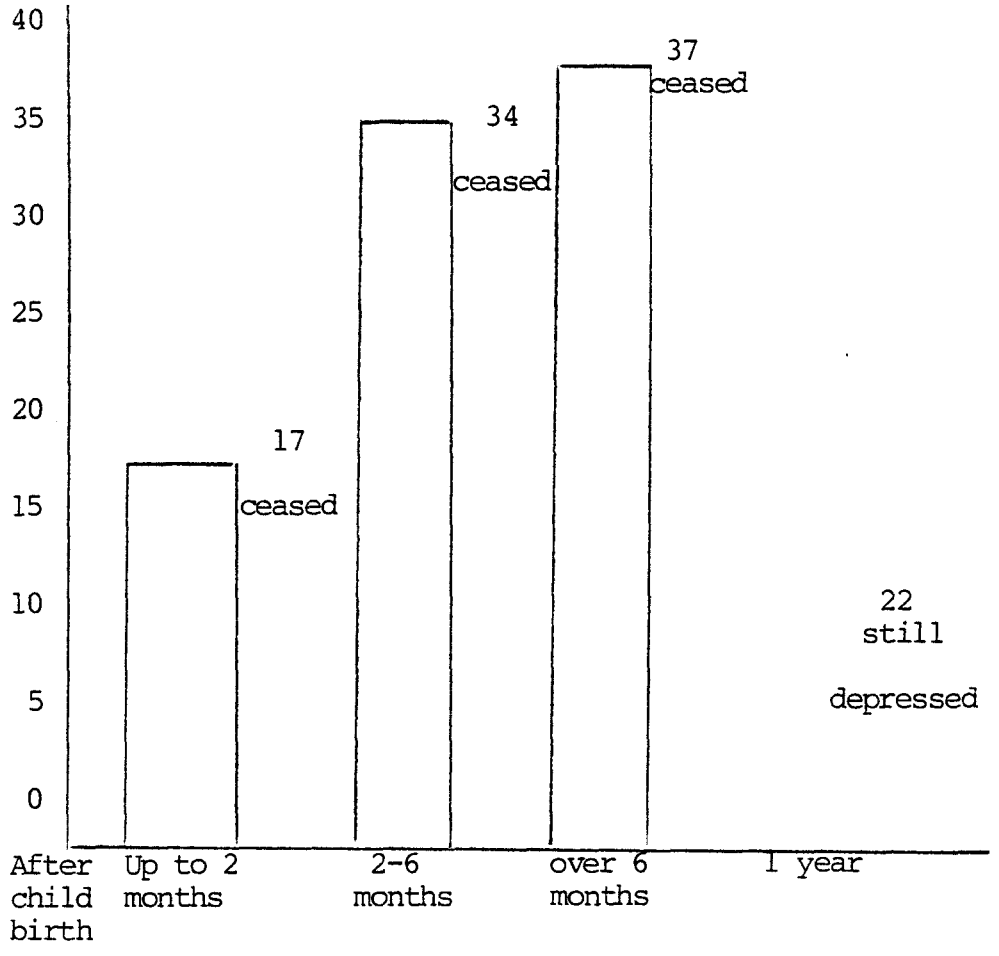
Table 17 shows when the mothers felt that they had recovered from their depression; seventeen (15% of 110 mothers) felt well again within eight weeks of childbirth, improvement occurred for another 34 mothers (31% of 110 mothers) between two to six months postpartum, and a further 37 mothers (34% of 110 mothers) in the latter half of the year. Thus for 86% of the 110 mothers (86%) the depression resolved during the year.

Some 22 mothers were still depressed after a year, these included the 7 mothers who still felt depressed at the end of the 13-month follow-up period and the 15 mothers who felt depressed for a few days at a time periodically throughout the year.

TABLE 17

WHEN THE MOTHERS RECOVERED

Total n = 110 depressed mothers



Source: Mothers' Questionnaire

OTHER TESTS OR PERSONS DESCRIBING THE MOTHERS' DEPRESSION

6.3. OBJECTIVE DETERMINANTS OF DEPRESSION

In this section the discussion concentrates on the opinions of the family practitioners and the health visitors about which mothers were depressed, and the diagnoses determined by psychiatric screening tests.

The Clinical Opinion of the Family Practitioners

There are four points to be noted about the family practitioners' opinions, as follows:

a. The family practitioners were not asked to report on all mothers (see Sample Response in Chapter 5.8).

b. Some mothers may not have seen the family practitioner during the study year and if they had, unfortunately, it is not known if the mothers talked about depressive feelings.

c. It has been suggested that mothers often do not consult their family practitioners with depression, and if they do, he may be unsympathetic (Welburn, 1980). This was mentioned a number of times by mothers in the present study too (noted also in the case study in Appendix ○).

d. The recording schedules were directed to a particular family practitioner (the one with whom the mother was registered) and, if he was in a group practice, it was possible the mother had consulted one of his partners. The recording schedule had not allowed for this alternative.

One hundred and sixty one recording schedules (FPRS) were completed and returned by the Family Practitioners. The 161 schedules covered 80 of the 110 mothers in the depressed group, 62 of the 94 mothers in the non-depressed group and 19 of the 31 mothers in the unsure group. The family practitioners judged that 19 (12% of 161) mothers had been depressed at some time during the months since their confinements.

TABLE 18

FAMILY PRACTITIONERS' DIAGNOSES

	Completed recording schedules (Total n = 235 in group)	Mothers diagnosed Postnatally Depressed	% of those assessed
Depressed group	80 (110)	13	16
Non-depressed	62 (94)	2	3
Unsure group	19 (31)	4	21
Total mothers	161 (235)	19	12

Source: Family Practitioner Recording Schedule

In Table 18 a big divergence of opinion is noted between the depressed mothers' opinions and the family practitioners' diagnoses. The family practitioners thought 21% (four of 19 mothers) of the unsure group had had postnatal depression, and they confirmed the postnatal depression in 13 out of 80 mothers (13%) in the depressed group.

The author assumed that the family practitioners used the mothers' medical records to provide the information required to complete the recording schedules 15 months after the mothers' deliveries. At what point during the 15 months the mothers had consulted them was not asked.

Very few mothers diagnosed as depressed by the family practitioner were prescribed medication, and only four (2.5% of 161) were referred to a psychiatrist, but the numbers were too small to be of statistical importance. These retrospective results, although inadequate for re-confirming the presence of clinical depression in the group of 110 depressed mothers, were certainly interesting. Two earlier family practitioner studies (Tod, 1964 and Ryle, 1964) found a 3% postnatal

depression incidence during the postnatal year, so the incidence of 12% noted in the present study was much higher. Tod stressed that he was only reporting severe cases of depression, which were being referred to psychiatrists, therefore he excluded less severe but still disabling depressions (Kumar, 1982). In a more recent prospective study Playfair and Gowers (1981) reported that 10% (62 of 618 mothers) were diagnosed as postnatally depressed at three months postpartum, by 64 general practitioners working throughout the British Isles, as against the 12% noted retrospectively by family practitioners in the present study.

The 62 family practitioners in Playfair and Gower's study actually searched for symptoms in their sample of 618 mothers. During interviews the morale of the mothers and the presence of any of 13 preselected symptoms were recorded. They found 150 of the 618 mothers (24.3%) had three or more symptoms of depression at, or about three months postpartum and of these 62 (10%) had six or more symptoms. Seventeen mothers (2.75%) were referred to a psychiatrist. This is very similar to the 2.5% referred to psychiatrists in the present study. Unfortunately Playfair and Gower's results only cover one stage in the postnatal year, the first three postnatal months, therefore they cannot be compared with those in the present study. In addition the family practitioners in the present study had not been asked to search for postnatal depression, therefore their assessments could only have been on those patients who had consulted them and who had exposed their depressive symptoms.

It was probable that the family practitioners in the present study only diagnosed as depressed the mothers most markedly afflicted, which might explain why the mothers' subjective opinions of 110 out of 235 (47%) postnatally depressed was considerably higher than that of the

family practitioners.

The Professional Opinions of the Health Visitors

At the end of the postnatal year health visitors reported that they thought a total of 39 mothers had been depressed for two weeks or longer, seven of these mothers did not return their questionnaire and were therefore not included in the final sample of 235 mothers, and a further five said that they had not felt depressed for two weeks or longer. Thus the health visitors recognised only 27 of the 110 depressed mothers (25%), shown in Table 19.

Although the health visitors recognised considerably more postnatal depression than the 12% recognised by family practitioners, they only noted a small proportion of those mothers defined as depressed from the mothers' own subjective opinions. These results were surprising, as contrary to the family practitioner, a considerable part of the health visitor's work is searching for health problems. These results are discussed more fully in Chapter 8, which is devoted to the health visiting care of mothers.

TABLE 19

MOTHERS* THAT HEALTH VISITORS THOUGHT HAD HAD POSTNATAL DEPRESSION

Health Visitors Opinions	Mothers Depressed	Non-depressed	No MQ
No	83		
Yes	27	5	7
Total Mothers	110		

Source: Health vistor recording schedule 2.

* This table includes mothers from the depressed and non-depressed groups, and also the 7 mothers not categorised as they did not return their questionnaires.

Psychiatric Screening Tests

As described in Chapter 4, it was decided to complement the subjective and family practitioner assessments of postnatal depression by using for at least some cases, Pitt's Anxiety Test (PAT) and the Crown-Crisp Experiential Index (CCEI). This was done for Sample 1 which consisted of 77 mothers who were selected from five practices of family practitioners who probably represented the usual population variations in the Health District (this is discussed in Sampling Method in Chapter 4).

1. Pitt's Anxiety Test

This test scored and measured mothers' anxiety levels in the 28th antenatal week (or 12 weeks before the expected date of confinement) and six weeks postpartum. The anxiety score was the postnatal score minus the antenatal score.

Pitt, in his own study (1968), interviewed as potential postnatal depressives, all mothers whose postnatal anxiety test scores had increased by more than six points. He also interviewed a "random selection of those whose scores were unchanged or diminished". The test scores on his own sample are shown in Table 20.

TABLE 20

PITT'S OWN ANXIETY TEST SCORES

Postnatal score minus Antenatal score	Mothers	%	Mothers diagnosed as depressed %
6 or more	34	39	79
1-5	16	18	12
0 or less	37	43	11
Total Mothers	87	100	

Source: Pitt, 1968

During this psychiatric interview Pitt found that 79% of the mothers who scored six or more points were depressed. This contrasted with 12% of those with a score of 1-5 and 11% of those who scored less than nil. Pitt maintained it was therefore clear that a score of six or more points was highly likely to be associated with clinical postnatal depression.

Scoring in Present Study

In the author's study 76 mothers in Sample 1 actually completed Pitt's Anxiety Test, six weeks after childbirth. The results of this test showed that well over half the mothers had a postnatal score lower

than their antenatal score. On the other hand just under a quarter of the mothers had an increase of six or more points in their postnatal scores. They were therefore highly likely to be postnatally depressed. These results are shown in Table 21.

TABLE 21

PITT'S ANXIETY TEST SCORES FOR 76* MOTHERS IN THE PRESENT STUDY

Postnatal score minus Antenatal score	Mothers	%
6+	18	24
1-5	8	10
0 or less	50	66
Total Mothers	76*	100

Source: PAT Tests 1 and 2

* One mother felt too depressed to complete the test six weeks after her confinement: she was excluded from the table as no postnatal score was available.

Discussion of Test Results

It will be seen from Table 21 that the proportion of mothers scoring highly on Pitt's anxiety test was less than two-thirds of the proportion found in Pitt's own study, and this difference was highly significant statistically ($X^2 = 8.11$, with two degrees of freedom; $p < 0.005$).

A possible explanation for the significant statistical difference,

is given in the text below, when comparing Pitt's, Breen's and the author's test scores.

Breen (1975) also used Pitt's Anxiety Test to measure postnatal depression, and Table 22 shows her test scores for Pitt's Anxiety Test; these are particularly relevant as the 51 mothers in her study completed the tests entirely in the community (as in the present study).

Breen's mean test scores (in Table 22) were compared with the author's shown in Table 21. The mean score in the author's sample was -1.7 (sd 11.3) and Breen's mean score for the same test was +1.9 (sd 9.32). When the Z test was applied to these two scores to estimate the statistical significance for the difference between the means, the result of Z = 0.85, showed no statistical significance.

TABLE 22

PITT'S ANXIETY TEST RESULTS IN BREEN'S (1975) STUDY

Postnatal score minus Antenatal score	Mothers	%
6 or more	11	21.5
1-5	6	11.5
0 or less	34	67.0
Total Mothers	51	100.0

In the preceding paragraphs Pitt's and Breen's test scores were each compared separately with the author's own scores (all three having used Pitt's Anxiety Test). A statistically significant difference was found between Pitt and the author's scores but no difference between the author's and Breen. This could have been partly because Pitt's Tests

were completed in hospitals, whereas Breen's and the author's tests were completed in the community, away from hospitals.

However, there were other differences, namely the sample of mothers in each category. Pitt's sample, in Table 20, included all mothers who scored six points or over (one category), and a miscellaneous selection of mothers from the other two categories (those mothers scoring 1-5 points, and those scoring 0 or less) whereas in both Breen's (in Table 22) and the author's sample (in Table 21) all the mothers who completed the test were included, whatever their score.

Curiously, it is shown in Table 20 that Pitt interviewed 87 mothers and found 33 (38%) fitted his criteria and were therefore diagnosed as depressed. This figure is very different from the 10.8% depressed mothers mentioned in his paper (1968). Pitt derived the 10.8% by calculating the percentage of the 33 mothers (found depressed on interview) from his total sample of 303 mothers, instead of the miscellaneous sample of 87 women. This difference has been emphasised because Pitt's own results have frequently been quoted during the last 15 years, and are still used in official documents. For example the recent Health Education Council leaflet about postnatal depression mentions Pitt's figure of 10.8% (Health Education Council, 1982).

In the present study, it had been hoped to use the results of Pitt's Anxiety Test in Sample 1 for determining the numbers of depressed mothers in the total sample (both Sample 1 and 2). No statistical difference was found between Samples 1 and 2 in other respects, therefore the statistical findings in Sample 1 could be expected in the combined Samples 1 and 2. At the two-month stage, a 28% incidence of postnatal depression in both samples 1 and 2 was assessed using the mothers' opinions, which was consistent with the 24% assessed using

Pitt's Anxiety Test. These results suggested that if mothers had completed psychiatric screening tests throughout the year that the test results might also have been found consistent with the total postnatal depression incidence of 47% (110 mothers' opinions out of a sample of 235 mothers) found in the present study,during the postnatal year.

Pitt's and other postnatal depression screening measurements are discussed further at the end of the following section on the Crown Crisp Experiential Inventory.

THE CROWN-CRISP EXPERIENTIAL INDEX

The second self-assessment test, used for screening psychiatric illness, was the Crown Crisp Experiential Index (CCEI). The test was used firstly for supporting Pitt's Anxiety Test findings, six weeks after childbirth, and also to screen depressed and anxious mothers 13 months after childbirth. Crown and Crisp designed the CCEI to obtain a total score which would provide a measurement of general emotionality or "neuroticism", together with profiles of six sub-scales.

Every mother in the Depressed Group, see Table 12, mentioned suffering depression or anxiety or both in the postnatal year, and these symptoms are reported in many cases of postnatal depression research.

Of the six sub-scale dimensions, only two, namely free-floating anxiety and depression seemed likely to be relevant for the mothers completing the Index. The four other sub-scales were phobic anxiety, obsessionality, somatic anxiety and hysteria. While it would be interesting to examine these sub-scales for each mother, they were not directly relevant to the present study, and were therefore excluded. Crown and Crisp's definitions of the two dimensions used were described

in Chapter 4, but are repeated here.

Free-Floating Anxiety (FFA):

> "The patient is afraid but unlike normal fear, there is no discernable object of which he is afraid."

Depression (DEP):

> This means a sadness of mood, difficulty in thinking clearly and slowing of actions and activity.

The sub-scale scores of the Crown-Crisp Experiential Index are normally divided into age groups each covering categories of 10 years; the ages of the mothers in Sample 1 were 17-44 years, and fell into three of these categories. Table 2 in Chapter 4 shows the sub-scale scores of free-floating anxiety and depression for the general female population in these age categories, and also a combination of the 3 age categories. The combined age category scores for the present study are shown in Table 23 and were tested using the Z score test against those in the general population study shown in Table 2, Chapter 4. The Z score indicated where the CCEI score was placed with respect to the mean of the distribution of the depression scores ofthe general female population.

The depression scores were found to be significantly different to those in the general population. The mean depression score of the general female population in the age group 17-44 years was 3.5 (sd 2.7), shown in Table 2, whereas the mean score of Sample 1 was 4.4 (sd 4.0), six weeks after childbirth, when the Z test was applied to these two scores $z = -2.26$; similarly, thirteen months postpartum, the total mothers in Sample 1 and those in the Participant Observation Group had a mean depression score equal to 4.4 (sd 3.1), when the Z test was applied to the latter score and the mean score (3.5, sd 2.7) of the

general population Z=-2.59. Thus the findings in the present study suggested that many women were more depressed at the test times of six weeks, and thirteen months after childbirth than had been found in the general female population, however a proportion of the latter could also be mothers in the year after confinement.

TABLE 23

CCEI 1 SCORES FOR MOTHERS IN SAMPLE 1 AT SIX WEEKS, AND SAMPLE 1 AND THE PARTICIPANT OBSERVATION GROUP AT 13 MONTHS

Samples	No.	Age	Free-Floating Anxiety		Depression	
			Mean	SD	Mean	SD
6 weeks						
Sample 1	77	17-44	5.8	3.9	4.4	4.0
13 months						
Sample 1	44					
P.O.G.*	59					
and together	103	17-44	6.3	4.0	4.4	3.1

*P.O.G. -Participant Observation Group

As mentioned above when the CCEI depression scores were tested against the general female population, the study scores were significantly higher at both test times of six weeks and 13 months. However, no significant difference was established between the anxiety sub-scale scores of the mothers in the present study (shown in Table 23) and those of the general female population (shown in Table 2). This cannot be explained especially as many writers and researchers link anxiety and postnatal depression (Pitt, 1968; Cox & Kendell; Snaith

1982) and Snaith (1982) stressed that anxiety and irritability were symptoms in postnatal depression which overshadowed the core depressive symptoms.

He noted these symptoms with interest, as, he said:

> "Traditional psychiatry separates anxiety states from depression and supposes young mothers presenting with pronounced anxiety symptoms to have a neurotic disorder resulting from some flaw in their personality....".

The CCEI 2 was completed by 44 mothers in Sample 1 and 59 mothers in Sample 2, 13 months postpartum. (No statistical difference was found between Sample 1 and 2, as shown in sampling response in the chapters.) The 44 mothers in Sample 1 included all those completing the longitudinal study whereas the 59 mothers were all those in the participation observation group completing the longitudinal study. (The sampling of the participant observation group of mothers was "skewed" to include mothers "at risk" of depression, as described in the method of sampling).

The anxiety and depression CCEI sub-scale scores of the 103 mothers were compared, and are shown in Table 24. T-tests were done between those mothers defined depressed using Pitt's Criteria, and those not defined depressed, those mothers not sure whether they were depressed, or who felt depressed for only a few days were excluded.

There were significant differences in the t-test for both sub-scales:

Anxiety, $t = 2.87$; $p < 0.005$ and

depression, $t = 2.22$; $p < 0.02$,

In each sub-scale the group of mothers assessed depressed according to Pitt's criteria had the higher scores. However 16 mothers in the depressed group and four mothers in the non depressed group scored above 6.2 (that was above the mean depression score = 3.5 plus one sd = 2.7).

Nevertheless there was still a significant difference between the scores of the 16 depressed mothers, and the 4 non depressed ($\chi^2 = 5.2$, for one degree of freedom: $p < 0.01$).

TABLE 24

CCEI 2 ANXIETY AND DEPRESSION SUBSCALE SCORES

Subscale Scores	Subjectively assessed Depressed Mothers				Subjectively assessed Non-depressed			
	Anxiety		Depression		Anxiety		Depression	
	No.	%	No.	%	No.	%	No.	%
0-6 (cut off point 6.2)	23	44	36	69	26	68	34	89
7-13	25	48	16	31	11	29	4	11
14-16	4	8	-	-	1	3	-	-
Total mothers	52	100	52	100	38	100	38	100

The scores of both Pitt's Anxiety Test and the Crown-Crisp Experiential Index I (CCEI I) indicated a 24% and 29% depression incidence, respectively, six weeks postpartum. Disappointingly no statistical intercorrelation was found between the results of these 2 tests, using the F-test . Perhaps this was because these 2 tests measured different things. Pitt's test indicated those mothers whose anxiety had increased postpartum, whereas the CCEI indicated the presence of depression at the time of the test, and therefore could include some mothers who might already have been depressed in the antenatal months; mothers found postnatally depressed in Pitt's Anxiety

Test may also have been depressed antenatally, but the anxiety test measured an increased depression.

Nevertheless the CCEI test showed statistically significant more postnatal mothers were depressed than those in the general population.

Although Pitt and both CCEI 1 and 2 clearly showed depression in significant numbers of postnatal mothers at the time of the tests, 6 weeks and 1 year postpartum, they did not cover the in between months. Whereas, the mothers defined depressed using Pitt's 4 Criteria (Table 16) included mothers depressed at these, and any other times in the study period. Therefore, the group of mothers screened depressed using Pitt's criteria were used for the basis of all the subsequent analyses.

6.4. CHILDBEARING STRESSES WHICH MAY BE ASSOCIATED WITH POSTNATAL DEPRESSION

Four groups of stressful life events directly associated with childbearing are considered in this section; these are previous losses and bereavements such as a termination of pregnancy or a stillbirth, complications of pregnancy, difficulties of the birth process and problems with the babies.

a. Earlier Bereavements associated with Childbirth

Miscarriages (spontaneous and induced), stillbirths and previous deaths of children were included in this category of bereavements. Slightlty more depressed mothers than non-depressed mothers had

experienced a miscarriage of pregnancy, as shown in Table 25. Although differences were not statistically significant this was an interesting point as miscarriages, spontaneous or otherwise, are relatively common and often the health carers do not realise that their patients may have some unresolved pain about these bereavements.

TABLE 25

MOTHERS WHO HAD PREVIOUSLY HAD A MISCARRIAGE, A STILLBIRTH OR A CHILD WHO HAD DIED

Miscarriages or Termination	Mothers			
	Depressed		Non-depressed	
		%		%
Nil	88	80	81	86
1	17	14	10	11
2	4	5	2	2
3	1	1	1	1
Total Mothers	110	100	94	100
Stillbirth				
Nil	107	97	92	98
1	2	1	1	1
2	1	2	1	1
Total Mothers	110	100	94	100
Deceased Child				
Nil	108	98	92	98
1	2	2	2	2
Total Mothers	110	100	94	100

Interestingly a few mothers in the present study described, spontaneously, recent bereavements which they themselves believed were factors contributing to their depressed feelings; these were not

examined systematically in this study, but one mother said:

> "I have felt depressed most of the year since the birth of my baby, but as my mother died very suddenly at this time I am not sure how much of this was postnatal depression or grief."

b. Pregnancy

There are physical and emotional events occurring in pregnancy that are called "complications of pregnancy" by health care professionals; these include those directly related to the pregnancy, such as pre-eclamptic toxaemia or a multiple pregnancy, and also other conditions such as diabetes or depression which may be totally unrelated to the pregnancy, but which also affect the mothers' general physical condition, their feelings of well-being, and which may generate anxieties about the health of their unborn babies.

In Table 26, the complications of pregnancy amongst mothers in the Depressed Group are compared with the complications in the Non-Depressed Group. Considerably more mothers in the depressed group are shown to have had complications of pregnancy; seventeen of the depressed mothers had 31 complications whereas 5 mothers in the non-depressed group had a total of 9 complications. The difference between these two groups was statistically significant $X^2=5.27$, $p<0.02$. This finding should assist primary health care workers, including the health visitors to identify a proportion of those mothers 'at risk' of developing postnatal depression, especially as the primary health care workers can fairly easily gather information concerning the complications of pregnancies.

TABLE 26

COMPLICATIONS OF PREGNANCY

Mothers with Complications	Mothers			
	Depressed	%	Non-depressed	%
Leading to being unwell:	18	16	4	5
Pre-eclamptic toxaemia	5		2	
Cystitis	2		0	
Fibroids/cysts	1		0	
APH	4		1	
Unwell mother	6		0	
Depressed feeling	0		1	
Leading to anxiety:	13	12	5	4
Twins	4		0	
Prematurity	4		3	
Incompetent cervix	5		2	
Total complications *	31		9	
Mothers with complications	17	15	5	5
Mothers without complications	93	85	89	95
Total Mothers	110	100	94	100

* More than one complication per mother
Source: Health Visitor Recording Schedule I

b. The Birth Process

In the Mother's Questionnaires many mothers referred to the traumatic effects of difficult births and how these had effected their emotional feelings during the postnatal year. Kitzinger (1978) and Oakley (1979) are amongst many authors who have referred to this phenomenen. Therefore in the present study the birth experiences of the depressed and non-depressed mothers were compared; the results, in Table 27 showed little difference between the two groups for any type of

delivery, apart from those mothers who had had a caesarian section, but this was not statistically significant. Interestingly Cartwright (1980) found an increase of depressed feelings amongst those mothers whose labour had been induced, unfortunately information was not gathered about labour inductions in the present study.

TABLE 27

COMPLICATIONS OF THE BIRTH PROCESS

Complications	Mothers			
	Depressed	%	Non-depressed	%
Breech	2	2	2	2
Forceps	10	9	10	11
Caesarian Section	8	7	4	4
Ventouse Extraction	3	3	1	1
Mothers with complications	23	21	17	18
Mothers without complcations	87	79	77	82
Total mothers	110	100	94	100

d. Problems with the Baby

There were many opportunities in the schedules for the interviewer/health visitor to discuss with the mothers, the health and other problems of their babies. The mothers may have experienced additional strain if their babies were born with, or later developed health problems or other problems, for example difficulties with feeding. These stresses might have precipitated or encouraged depression in the mothers. In the two weeks following the confinements, 36 of the 110 mothers in the depressed group and 27 of the 94 non-depressed mothers had had problems with their babies. The two groups are compared in

Table 28, but the difference was not statistically significant.

TABLE 28

BABY PROBLEMS* 2 WEEKS AFTER BIRTH

Problems	Mothers			
	Depressed		Non-depressed	
		%		%
Baby problems	36	33	27	29
No problems	64	77	67	71
Total mothers	110	100	94	100

* The problems included feeding difficulties and ill-health.

Table 29 shows which mothers had babies with problems when the babies were six weeks old. The information shown in Tables 28 and 29 is not comparable because the source of the information used in Table 29 was the Regular Health Visitor Recording Schedule, and there was no information about the babies of 36 (33%) of the 110 depressed mothers and 41 (44%) of the 94 non-depressed mothers because the Shortened Version of the Health Visitor Recording Schedule had been used for their mothers which did not include all the questions about their babies.

TABLE 29

BABY PROBLEMS* 6 WEEKS AFTER BIRTH

Problem	Mothers			
	Depressed		Non-depressed	
		%		%
Feeding	18	23	6	8
Thrush	6	8	2	3
Low birth weight	7	9	3	4
Unwell baby	9	11	6	8
Sore buttocks) Sticky eyes) Sticky umbilicus)	4	5	5	6
Congenital problems	3	4	2	3
Jaundice	1	1	6	8
Total Problems	48	61	30	40
Mothers with baby problems	35	31	25	26
Mothers with no baby problems	39	35	28	30
No information ** about baby problems	36	33	41	44
Total mothers	110	100	94	100

* More than one baby problem per mother.
** HVRS 1c (short) did not collect the information required for this table.

Source: HVRS 1c (Regular)

No statistical difference was found between the two groups of mothers shown in Table 29. However there was a significant difference between those mothers who had babies with feeding problems and those who did not. In the depressed group there were 18 babies (51%) with feeding problems out of the total of 35 babies with problems, whereas in the

non-depressed group of mothers there were only six babies with feeding problems (20%) out of a total of 25 babies with problems, the difference between the two groups of mothers whose babies had feeding problems was statistically significant ($X^2 = 4.57$, for one degree of freedom, $p<0.05$) This is a most important finding and is supported by other researchers such as Marginson (1981). It is very important for health visitors as they are the professional persons most associated with babies' feeding problems. What is not clear is whether the baby had a problem because the mother was depressed or whether the mother was depressed because the baby had a feeding problem.

However both the baby and the mother require understanding and help. Mothers find it hard to adapt to babies who are difficult to feed. The mothers' concerns include those for their babies' welfare and their own feelings of failure to mother their babies adequately. At the same time the mothers' are concerned about others' opinions about their perceived inadequacies, such as their husbands, their extended family, their friends and their health carers. While the mothers' anxiety and guilt is developing their difficult feeding babies are often restless, crying frequently, and poor sleepers. All these factors increase the mothers' tiredness and reduces their ability to be objective, which leads to mothers claiming that they cannot cope. Health visitors are in the front line to commence appropriate care for these mothers.

6.5. PSYCHOSOCIAL FACTORS ASSOCIATED WITH DEPRESSED MOTHERS

Several psychosocial factors may be associated with the feelings of depressed mothers and the following were investigated: marital status,

age, number of children, relationship with husbands, husbands' occupation and social class. The mother's relationship to her own mother was also considered together with information about whom the mothers invited to help them with their babies or their own problems; this provided valuable information about the mothers' close ties. Although the bereavements, discussed in 6.4, could have been included in this section on psychosocial factors only a few mothers were affected by bereavements, whereas the factors discussed in this section concerned each mother.

Marital Status and the age of Mothers who felt Excessively Anxious or Depressed

One hundred and five of the depressed mothers were married (95% of 110 mothers) four mothers were cohabiting (4%) and one mother (1%) was living alone. The age of these mothers ranged between 18 and 39 years (average age 26 years), and 11 mothers (10%) were under 21 years.

These results were similar to those in the non-depressed group: 88 mothers (94%) were married, their age ranged between 17-41 years (average age 26 years) and 12 mothers (13%) were under 21 years.

Partner's Occupation/ Social Class

The social class of the husbands or cohabitees, classified according to the Registrar General's Classification of Occupations, of the mothers in the depressed and non-depressed groups is shown in Table 30. There was no statistically significant difference between the depressed and non-depressed women according to social class although in social classes 2 and 3n a marked although not statistically significant difference can be noted.

TABLE 30

THE SOCIAL CLASS OF THE DEPRESSED AND NON-DEPRESSED MOTHERS CLASSIFIED BY PARTNER'S OCCUPATION
(Registrar General's Classification)

Social Class	Mothers			
	Depressed		Non-Depressed	
		%		%
1	8	7	11	12
2	13	12	7	7
3N	18	16	11	12
3M	20	18	21	22
4	19	17	17	18
5	4	4	5	5
unclassified *	8	7	6	6
6 (2)	3	3	0	0
7 (4)	17	15	16	17
Total mothers	110	100	94	99

* This category includes the unmarried mothers.

Those mothers whose partners were officers in the armed forces were categorised in Social Class 6 although they could have also been included in Social Class 2, whereas Social Class 7 included all other mothers whose partners' occupation had been recorded as 'navy or 'army' and these could possibly have been included in the Social Class 4 category. Table 30 shows little difference between the social classes of the groups of mothers and although there were less depressed than

non-depressed mothers in Social Class 1 and more depressed mothers (12%) than non-depressed (7%) in Social Class 2, these numbers were not statistically significant. This finding is consistent with other investigators' reports that the incidence of postnatal depression does not seem to be influenced by the subject's socio-economic status (Pitt, 1968 and Paykel et al., 1980).

The present study was designed to include mothers from all social classes as health visitors normally offer care to all postnatal mothers irrespective of social class.

Number of Children

Primiparous women (first baby) made up 60% (66 of 110 mothers) of those who were depressed and 55% (52 of 94 mothers) of the other group, as shown in Table 31. Although a higher proportion of mothers having their first babies became depressed, 61% (67 out of 110 mothers) as against 39% (43 out of 110) for those having second or later babies, this difference was not statistically significant. However the information enables one to make the point that postnatal depression is by no means particularly a problem with mothers having their first baby. In the survey those having second or later babies had almost exactly even chances of being depressed or not. A few of the mothers already had step children; all were in the depressed group, but the numbers were so small as to have no statistical significance.

TABLE 31

THE NUMBER OF CHILDREN OF THE DEPRESSED AND NON-DEPRESSED MOTHERS

Number of children under 5 years	Mothers			
	Depressed	%	Non-depressed	%
1	67	61	53	56
2	41	37	37	39
3	1	1	4	4
4	1	1	0	0
Total mothers	110	100	94	100
over 5 years				
0	89	81	71	75
1	11	10	13	14
2	8	7	9	10
3	2	2	0	0
4	0	0	0	0
5	0	0	1	1
Total mothers	110	100	94	100
Stepchildren				
Yes	2	2	0	0
No	108	98	94	100
Total mothers	110	100	94	100

Relationship with Partner

A number of different aspects concerning the mothers' relationships with their husbands were investigated. As was shown in Table 30 there was little difference between the groups in terms of formal marital status, with the great majority of both being married, and with marital status being apparently unrelated to the incidence of postnatal depression. Two other indicators of the state of the marital relationship were also used - the presence of the father at the birth, and the mothers' own interpretation of changes in their partner's behaviour since the birth of their baby (see Table 33).

Presence at the birth of the baby was not associated with a statistically significant difference between the groups although, interestingly, the depressed mothers were more likely to have had their partner present than the non-depressed (shown in Table 32)

TABLE 32

FATHERS' PRESENCE AT THE DELIVERY OF THEIR BABY

Presence at the delivery	Mothers			
	Depressed		Non-depressed	
		%		%
Yes	81	27	63	67
No	27	24	31	33
Unknown	2	2	0	0
Total mothers	110	100	94	100

Source: Health Visitor Recording Schedule 1

A significantly greater proportion of depressed mothers perceived their husband's behaviour to have changed negatively during the postnatal year ($X^2 = 5.77$, for 1 degree of freedom; $p < 0.05$). This information was collected in the Mothers' Questionnaire completed at the end of the year, and if the mother had felt depressed for some time it was possible that she had developed negative perceptions of other people's behaviour including her partner's. It is impossible from this data to know if the apparent change in the partner's attitude was a cause or a product of the mother's depression. However the fact of the association is suggestive, although it must be remembered that even

among the depressed group 80% of husband's attitudes were not seen to have changed negatively.

TABLE 33

THE MOTHERS' INTERPRETATION OF CHANGES IN THEIR PARTNERS' ATTITUDES IN THE YEAR AFTER CHILDBIRTH

The Change	Mothers			
	Depressed		Non-depressed	
		%		%
Too busy	7	6	1	1
Complete disinterest in family	3	3	1	1
Irritable with children	8	7	1	1
Depressed	2	2	-	-
Libido decreased	1	1	-	-
Divorced	-	-	1	1
Left home	-	-	2	3
Not married	1	1	1	1
Husbands who changed	22	20	7	7
Husbands not changing	88	80	87	93
Total mothers	110	100	94	100

Source: Mothers' Questionnaire

Relationship with her own Mother

The information about the relationship of the mother to her own mother was noted in the answers the mothers gave to the questions in the Mothers' Questionnaire at the end of the postnatal year; the questions included where the maternal grandmothers lived (Table 34), and whether

the mothers in the present study had asked the maternal grandmothers for help with their babies, or even for help with the mothers' own problems. Another question asked was whether the mothers in the present study were preparing to provide their own children with a similar upbringing to their own (Table 35).

TABLE 34

GEOGRAPHICAL DISTANCE BETWEEN THE MOTHERS AND THEIR OWN MOTHERS

Distance between the mothers and the maternal grandmothers	Mothers			
	Depressed	%	Non-depressed	%
Less than five miles	48	44	36	38
Five to 50 miles	23	21	19	20
More than 50 miles	27	25	31	33
MGM * deceased	9	8	6	6
Unknown	3	3	2	3
Total Mothers	110	100	94	100

*MGM - Maternal Grandmother

Source: Mothers' Questionnaire

In most cases the mother's own mother was still alive, as shown in Table 34. There was little statistical difference between the groups concerning the distance away that the maternal mothers lived - 6% more depressed mothers had their own mothers living within five miles of their own home (44% for the depressed and 38% for the non-depressed), whereas there were 8% more mothers who were not depressed whose own mothers lived more than 50 miles distant (25% for the depressed and 33% for the non-depressed).

The mothers' attitudes to their upbringing were interesting, shown in Table 35. The information was gathered from the mothers at the end

of the postnatal year, by which time they were able to base their opinions on some experience. The mothers were asked to give reasons for wishing to rear their children in a different way to their own upbringing. The author drew up a list of categories from all the given reasons, and then placed the mothers' principal opinion into what seemed to be the most appropriate category. The different attitudes between the groups of mothers about the methods of upbringing of their children are shown in Table 35. The difference between the two groups were just outside the statistical level of significance (X^2 =3.5, for 1 degree of freedom, $p>0.05$). Almost 50% of the mothers wanted to bring their children up differently, but proportionately more depressed mothers than non-depressed mothers wanted a change. Possibly these mothers were depressed because they had high expectations which were not borne out. The reasons given for wanting these changes suggested that the mothers were dissatisfied with their own childhood. It is curious to note that both groups were dissatisfied for almost the same reasons, but with one notable exception. Almost one in five of the dissatisfied depressed mothers felt that their own upbringing had suffered from 'overmothering', which perhaps can be summed up as meaning that the mothers had not been allowed sufficient previous opportunities to learn how to cope with stressful situations, or had not been encouraged to use their initiative and stand on their own feet. On the other hand if the maternal grandmother is available around the time of her daughter's confinement and continues to smother her, the new mother becomes confused and loses an opportunity to find and develop her own maternal identity.

Apart from this difference both groups of mothers shared dissatisfaction with much the same features of their upbringings -

parents who were too strict and showed little love (23% for the depressed who wanted to change, as against 32% of the non-depressed)- 'old-fashioned parents' (which may have some features in common with the previous category (23% and 30%)). Parents who looked after themselves and had little time for their children, coupled with those who relied on bribery in child care, accounted for 21% of the depressed and dissatisfied and 16% of the non-depressed but dissatisfied.

On the whole, therefore, the mothers' dissatisfactions with their upbringings were broadly similar, however, such dissatisfaction was possibly linked with depression, when elements in their upbringing had limited their own preparation for motherhood. It is perhaps a commentary on the upbringing of both groups that some 40 -50 percent expressed some dissatisfaction. How far in the event the mothers brought up their children differently remains to be seen.

TABLE 35

THE REASONS IN THE MOTHERS' OWN CHILDHOOD WHICH INFLUENCED THEIR PRESENT CHILDREARING METHODS

Category of reasons in mothers' childhood	Mothers			
	Depressed	%	Non-depressed	%
Very strict and little love	13	12	12	13
Little time for children and no discipline	9	8	6	6
Overmothered	11	10	1	1
Old-fashioned parents	13	12	11	12
Bribery and parents immoral	3	3	0	0
Very difficult to answer	2	2	2	2
Change of mother before the age of 11 years	3	3	4	4
Very unhappy parents	3	2	1	1
Total Reasons	57	52	37	39
No Reasons for change	53	48	52	55
Unsure and no reasons	0	0	5	0
Total mothers	110	100	94	100

Further information about the mother's relationship to her own mother is discussed in the next section.

6.6. THE MOTHERS' COMMUNITY NETWORK AND SUPPORT SYSTEMS

Three aspects of the mothers' community network and support systems were analysed: who was available to help them at the time of their confinements (Table 36), who the mother asked for help (in Tables 37, 38 and 39 and partially discussed in the paragraph above), and which community groups were used by the mothers (Table 40).

TABLE 36

PRIMARY PERSON AVAILABLE TO HELP MOTHERS AFTER THEIR CONFINEMENTS

Available Person	Mothers			
	Depressed		Non-depressed	
		%		%
Maternal Grandmother	60	55	58	62
Paternal Grandmother	11	10	3	3
Sister	4	4	1	1
Sister-in-law	2	2	0	0
Husband	1	1	0	0
Others	1	1	0	0
Occasional	10	9	12	13
No help	21	19	20	21
Total Mothers	110	100	94	100

Source: Health Visitors' Recording Schedule 1

Table 36 shows that the maternal grandmother was the primary person available to help around the time of their confinements for more than 50 per cent of the depressed (55%) and non-depressed mothers (62%), although interestingly these figures show that seven per cent more mothers in the non-depressed group did not have this opportunity. Additionally the paternal grandmother (mother-in-law) was the primary person available for 10% of the depressed mothers compared with only 3% for the non-depressed. Although these findings are not statistically significant they do suggest an association with the availability of the

maternal grandmothers and no development of postnatal depression. A possible reason for this could be that the help of the maternal grandmother may reduce mothers' anxiety and also provide physical help which may reduce mothers' tiredness. Perhaps mothers find it more difficult to get this assistance from the paternal grandmothers, simply because they frequently do not know one another very well, and because the mother-in-law relationship is often a tricky one.

Tables 37 and 38 noted who the mothers could ask for help for themselves and their babies. The type of help needed was not specified in the questions (this applied particularly to the babies), however the questionnaires were focussing on the mother's feelings when the question was asked about 'help for herself' and this probably influenced her answers, as shown in Table 38. The mothers mentioned up to three people whom they would ask for help for their babies, and for themselves.

TABLE 37

PEOPLE MOTHERS ASKED TO HELP THEM WITH THEIR BABIES

People* asked for help	Mothers			
	Depressed		Non-depressed	
		%		%
Maternal Grandmother	38	35	25	27
Husband or partner	36	33	23	24
Other family	9	8	7	7
Doctor	56	51	27	29
Health Visitor	72	65	57	61
Neighbours	14	13	6	6
No-one	0	0	1	1
Mothers asking for help	106	96	82	87
Missing cases	4	4	12	13
Total mothers	110	100	94	100

*The mothers could record up to three people

Source: Mothers' questionnaire

As shown in Table 37 more than two thirds of both the depressed (68%) and non-depressed (70%) groups of mothers claimed that they had approached the health visitors for help with their babies, other people approached included their own mothers and their husbands with slightly more depressed mothers (35% asked their mothers and 33% asked their husbands) than non-depressed (27% asked their mothers and 24% asked their husbands) doing so. None of these findings were significant.

However 56 (53%) of 106 depressed mothers and 27 (33%) of 82 non-depressed mothers approached their doctors for help with their babies and the difference was statistically significant (X^2 =7.43, for 1 degree of freedom, $p<0.01$). Possibly this finding is consistent with the earlier finding in Table 29 which showed that statistically more depressed mothers had a baby with a definite feeding problem, especially as the mothers of these babies would probably have asked their family practitioners to examine their babies, to make sure that there were no clinical problems.

TABLE 38

PEOPLE MOTHERS ASKED TO HELP THEM WITH THEIR OWN PROBLEMS

People* asked for help	Mothers			
	Depressed		Non-depressed	
		%		%
Maternal Grandmother	27	25	13	14
Husband or partner	41	37	25	27
Other family	6	5	6	6
Doctor	37	34	27	29
Health visitor	31	28	7	7
Neighbours	10	9	4	4
No-one	10	9	29	31
Only one person	44	40	77	82
Missing case	1	1	0	0
Total mothers	110	100	94	100

* The mothers could record up to two people.

Source: Mothers Questionnaire.

The mothers asked different persons for help for themselves than they had for their babies, shown in Table 38. Some mothers did not ask anyone, and the proportion was significantly higher for those who did not feel depressed, possibly because they did not require any help, (X^2 = 14.7, for 1 degree of freedom, $p<0.001$). For those mothers claiming to have only one confidante there was a similar marked difference between the two groups of mothers with 44 (47%) of the 110 depressed mothers stating this compared with a far higher proportion 77 (82%) of the 94 non-depressed group. Perhaps the non-depressed group did not need any help and were generally more independent people. The mothers asked the health visitors for help for themselves less frequently than they had for help with their babies, however significantly more depressed mothers did so, 31 (28%) out of 110 depressed mothers compared with 7 (7%) out of 94 non-depressed mothers (X^2 = 5.5, for 1 degree of freedom, $p<0.01$).

On further analysis it was found that when the health visitor was the only person the mother asked for personal help, there was no significant difference between the depressed and non-depressed groups. Also when there was only one person whom the mother would have asked for help it was more likely to have been the doctor than the health visitor, but the difference was not significant, as shown in Table 40. In Chapter 8 there is a discussion about whether the health visitors had thought that the mothers who had approached them for help had been depressed.

TABLE 39

MOTHERS WHO ASKED DOCTORS OR HEALTH VISITORS FOR HELP WITH THEIR OWN PROBLEMS

Person asked for help	Mothers			
	Depressed		Non-depressed	
		%		%
Doctors				
Asked: alone	13	12	19	20
" with Health Visitor	12	11	2	2
" with others	12	10	6	6
Not asked	73	34	67	51
Total mothers	110	100	94	100
Health Visitors:				
Asked alone	7	6	2	2
" with Doctor	12	11	2	2
" with others	12	11	3	3
Not asked	79	72	87	91
Total mothers	110	100	94	100

Source: Mothers' Questionnaire.

At the end of the year the mothers were asked which was the principal community group with which they had been involved and which might have given support. This may have produced an over simplified picture but the results are shown in Table 40.

TABLE 40

THE COMMUNITY GROUPS* ATTENDED BY MOTHERS

Group	Mothers			
	Depressed		Non-depressed	
		%		%
New mother	10	9	2	2
Church	4	4	4	4
NCBT	-	-	1	1
MAMA	2	1	1	1
Mother and Toddler	9	9	18	18
Child Guidance	1	1	1	1
Coffee with friends	30	27	25	25
None	57	50	47	48
Total mothers£	113	100	97	100

* One group per mother was categorised.
MAMA - Meet a Mother Association.
NCBT - National Child Birth Trust.
£Owing to a coding error which now cannot be traced this table includes 3 persons in each category from the non-sure group.

Source: Mothers' Questionnaire.

There were no significant differences between the mothers in the depressed and non-depressed groups regarding community group attendance. However, a higher proportion of non-depressed mothers attended mother and toddler groups; these groups are for toddlers therefore those mothers attending were probably not first time mothers and had already learnt about the benefits of using the community support systems. It was revealing that 50% of the mothers in both groups said that they attended no groups. In Table 40, about 25% of the mothers in both groups mentioned having coffee with friends, but in Table 38 it was

noted that only 9% of the depressed mothers and 4% of the non-depressed mothers would have asked neighbours (the author assumed that these included friends) for help with their problems. Possibly the mothers did not get personal help from their friends, or they did not realise that they were doing so. S. Henderson (1977) suggested that people did not always realise that they were gaining support from the people nearest to them, such as their closest family and friends.

SUMMARY OF FINDINGS IN THIS CHAPTER

Before continuing, a summary of the findings in this chapter is presented, particularly as there are many occasions, in Chapter 8, where the health visitor's opinion is compared with the mothers' opinions discussed in this chapter.

There were over 100 mothers (47%) who felt depressed or anxious for two weeks or longer after their confinement. (The onset, duration and cessation of this depressive period was shown in this chapter). All these mothers described at least two accompanying symptoms.

The family practitioners diagnosed postnatal depression in only 1 in 10 (10%) of these mothers and in 12% of the total population of 235 mothers in the study.

The results of Pitt's Anxiety Test, six weeks post-partum exposed postnatal depression in 21% of the sample of mothers.

The Crown-Crisp Experiential Index classified more mothers as

depressed, at both test times of six weeks and thirteen months after childbirth, than would have been found in the general population for the same age group.

A factor that may be associated with postnatal depression and was found to be significant was having a baby who had problems, particularly feeding.

A number of variables relating to health and social conditions were used to compare the depressed and non-depressed groups, but few of these showed statistically significant differences between the two groups. Complications of pregnancy had occurred stsistically more frequently amongst the deprerssed group. The depressed mothers noted more negative changes in their husbands and a significant number planned to rear their children differently from their own upbringing. More depressed mothers than others contacted their doctors for help with their babies if they had a baby problem, and also more depressed mothers asked their health visitors for help with their own personal problems. There were also other associations which seemed suggestive, and might have achieved statistical significance had the survey been conducted on a larger scale. In this category the author noted the surprising apparent association between not having the maternal grandmother available for help at the time of the confinement and the non-depressed group of mothers.

CHAPTER 7

MOTHERS' FEELINGS OF DEPRESSION OR ANXIETY

In Chapter 6 the mothers in the study were categorised into the depressed, non-depressed and not sure groups. These groups were categorised from the mothers' own opinions about how they had felt during the postnatal year. In this previous chapter various psychosocial, or life events, and medical factors, thought to be associated with postnatal depression, were also analysed. However in the current chapter the mothers' own reasons for feeling depressed are mentioned; these were stated by the mothers during the observed 6-month interview and in their diaries. These statements were made by mothers who felt depressed temporarily (for a day or two) and those in the depressed group (that is their depressed feelings fitted Pitt's 4 criteria for defining postnatal depression).

There are many good written accounts of 'how mothers feel before and after having a new baby'. One of these accounts is by Oakley (1979); she explained childbirth as the time when a woman first confronted the full reality of what it means to be a woman in our society. This happens particularly during her first pregnancy, being the moment of no return, when woman's work outside the home is severely affected. Oakley's accounts are through her eyes as a woman, about women having their first baby in the late 1970's, in a large industrial city. Her work was largely concerned with the first six months after childbirth.

In the author's study, 62 mothers visited by the researcher six

months postpartum were invited to keep diaries from this time, until the author visited them again 13 months postpartum. They were invited to write down and describe the times, if they felt excessively anxious or depressed. They were asked to state why they thought they felt like this, and what they did about it. This was a randomly selected sample (the method of sampling is discussed in Chapter 4); it included childbearing women of varying ages, parity and social class, who all lived in one large health district.

Although only few mothers completed these diaries it was particularly interesting to note how much information they provided about their feelings in this period (6 months to 13 months postpartum). For the purposes of this study these recorded feelings have been sorted into why the mothers thought that they became depressed, and also how they coped with these feelings.

THE REASONS THE MOTHERS GAVE FOR FEELING DEPRESSED.

The mothers´ statements about why they felt depressed are grouped into 8 categories below, nevertheless many of the problems could have been placed in more than one category.

1. Tiredness. In Chapter 6 the evidence showed that mothers noted tiredness as one of the major symptoms associated with their depression, and this symptom is always included in writings and research about postnatal depression.

> "I don´t know why I have been so fed up, sometimes I feel myself and then I start to feel tired and start to shout at everybody."

"I was so very tired."

"I felt very tired..... about a month after my husband went away and went to doctor."

"I feel so tired, not unhappy, just tired."

2. Life events and associations with their husbands.

Life events appear to be closely associated with postnatal depression, similar to general neurotic depression

"One of my other children needed an operation, followed by my mother going to hospital for tests and then she died."

"My mother would not accept that I was pregnant, because I am divorced. I really minded and was very, very depressed."

"My husband was away and I had no family nearby."

"The weather was bad and my husband was away."

"I got fed up having no money I can call my own."

"Having two small babies at 21 years was too much for me."

"My husband was away and we were worried about money."

"My husband's away, and when he was home we have sexual difficulties."

"My husband was weighed down with the responsibility."

"My husband was depressed."

3. Ill-health of the mother or her baby.

Illness appears to lower the mother's resistance and her coping abilities.

"Sometimes I felt I couldn't cope and my friends lived so far away, particularly as I was unwell and the baby was miserable."

"I couldn't cope any more, because the children were so unwell."

4. Baby and children.

Some mothers recognised a connection between their babies' difficulties and their own emotional feelings. This phenomenen has been described by other researchers; this connection was also found to be statistically significant in this study and shown in Chapter Six.

> "Straight after I had the baby I left hospital after 48 hours and the depression started then."
>
> "The baby keeps me awake all night and day. There is nobody living up here. To get anywhere you have to go on quite a journey."
>
> "I felt awful when the baby screamed. I was told it was colic. I did not feel satisfied by the explanation. I think to survive children you need enough sleep and time to yourself."
>
> "For the first six weeks I used to get depressed in the evening when the baby had colic."
>
> "I have a very difficult baby who screams a lot."
>
> "My baby is very unsettled."
>
> "I feel tied to the children. The world does not seem to be orientated towards them. All my friends without children seem to be free and easy."
>
> "I get down in the dumps because I am having another baby."

5. Fear, lack of confidence and loneliness.

> "I was so frightened."
>
> "I was so frightened I would hurt the baby."
>
> "I felt so unconfident."
>
> "I felt lonely and isolated."

6. Previous Depression.

There is research evidence connecting a previous depression with postnatal depression; this was described in Chapter 2. In the present study some mothers apparently recognised this connection

themselves, as shown below.

> "I suffer from chronic depression, which gets worse after having a baby. I was first treated when 5 years old ....." and another said
>
> "I was depressed before I had the baby and treated, but then my sister died when I came out of hospital with the baby and this set me off again."

7. Hormonal.

A possible connection between hormones and posnatal depression has created much interest and research; Dalton (1980) was one of these researchers.

> "Breastfeeding."
>
> "I had crying fits especially after the baby was born. I usually feel very miserable about the middle of the month and when my periods are due."
>
> "I have put down my depressed feelings to a number of facts, that I have been breastfeeding and have not had a period for ..... and I feel really rough ..... and have a terrible stomach-ache ..... like a period ..... a monthly type of feeling."
>
> "My husband says it is worse when my periods are due, but I am not sure ....."

8. Unknown.

The mothers find it particularly distressing when they cannot explain why they felt depressed at this time, which was supposed to be a happy time with a new baby.

> "I don´t know what it was, it lasted for three weeks and then I was alright, my husband thought I was lonely, I came out of it just like that, I think it was everything ....."
>
> "I don´t know what caused it."

HOW THE MOTHERS COPED WITH THEIR FEELINGS.

How the mothers said they coped with the problems of anxiety and depression provided very useful information and exposed areas where the mothers' needs were not met. This will be helpful for other mothers and their health carers, therefore these reasons are also categorised below.

1. How mothers managed on their own.

It appears from the statements below that the mothers tried hard to escape from the reality of motherhood.

"I went on an allergy diet".

"I cry, that releases some of the tension and then I can face another day.

"I cry".

"I smacked the sibling, had a cup of tea and let them both yell!" This was an interesting remark as it illustrated the use of aggression as a coping mechanism. The mother who made this remark did not mention any related guilt about this aggression.

"Went into bedroom for peace".

"Kept busy".

"When the children are in bed I have a good cry."

"I try to keep busy, I tried a part-time job but got too tired and so just keep busy."

"I spend the morning dozing."

"I watch TV and feel better."

"I go out a lot." (2 mothers)

"Go for a walk." (3 mothers)

"I take the car out."

"I go to the clinic to get out."

"Contact the health visitor." (3 mothers)

" I went to see the Doctor to get some tablets."

2. Use of the inner network system.

   a. Husband.

      "Nag my husband."

      "Talk to my husband."

      "Husband helped."

      "Good moan at my husband."

      "Husband took me out for a meal and drink."

      "Husband suggested I went to bed early."

      "Had a rest when husband came home."

   b. Extended family.

      "Maternal grandparents came to stay" (3 mothers).

      "Phone my mum" (3 mothers).

      "My family helped."

      "Phoned my dad who comes to see me and takes me to my mum."

      "Grandma took children out."

      "Went to mother-in-law for the day."

      "Went to my sister-in-law."

      "Grandma takes the children."

3. Outer network.

      Friends.

      "Had coffee with friends."

      "A day out seeing friends which was something for me."

      "Went to play badminton with a friend."

      "Rang a friend."

      "Went out for a picnic."

      "Went out shopping with a friend."

"Went out shopping with a friend."

"Had coffee with a friend."

"I leave the baby with a friend and go out for half an hour."

"Help of friends and neighbours."

Unfortunately the above information was only gathered from the few mothers who completed the diaries (only 24 mothers). Possibly the most depressed mothers were not amongst these contributors and therefore these comments came from those mothers who suffered the least. Additionally, the less literate may have also failed to complete the diaries.

It was interesting to find that those mothers, who did complete diaries, used their own resources and network systems to share and alleviate their distress far more than they used the health carers. Van der Eyken (1982, p166) suggests that:

> "In the language of psychotherapy, befriending and 'being with' a person is a voluntary function. While 'doing to' is a task for the professional".

Perhaps the task (doing) for the health professionals is to encourage the mothers' inner network systems (their families) and their community networks, including the voluntary organisations to provide more befriending for mothers.

Taking these comments and comparing them with who the mother would turn to for help in Chapter 6, is interesting, and appears to reveal some disparity. In Chapter 6, Table 37 , only 10 out of 110 depressed mothers (9%) and 4 out of 94 non-depressed mothers mentioned using their neighbours (possibly friends), to help them with their own problems, particularly depression, whereas it has been noted in the present chapter that many mothers mentioned contacts with their friends, when describing

how they coped with depressed feelings. This disparity may confirm S. Henderson's statement (1977) that depressed persons do not necessarily appreciate nor realise the support they receive from the persons closest to them. It is also quite likely that this disparity arose from the way the questions were asked.

CHAPTER 8

THE HEALTH VISITING CARE OF THE MOTHERS

8.1. INTRODUCTION

In this chapter there is a description of the system of health visiting care given to the postnatal women in the sample. As mentioned previously the principles according to which the system of health visiting care was provided in the district, were based on the recommendations of the Court Report (1976), the Council for Education and Training of Health Visitors (1967 and 1977) and Henderson's report called Health Visitors in Hampshire (Henderson J., 1977).

The information in this chapter is presented longitudinally describing the process of health visiting and starting with the early "contact" between health visitors and mothers. A certain minimum number of meetings or contact times in the form of home visits, clinic and group sessions and telephone calls, were necessary for the provision of any health visiting care; it would normally be the health visitor's responsibility to create opportunities for these meetings and methods of contact. In this chapter these contacts are described first, especially as most of the information described in the other sections of the chapter could only have been collected after these meetings.

The health visitors' understanding of the mothers' needs and the health visiting care they provided was investigated in three areas.

Firstly, health visitors in their preventive role were expected to promote health and identify ill-health early and provide surveillance of high risk groups (CETHV, 1967). In this connection mothers who were "at risk" of becoming depressed needed specific health care, therefore the

health visitors' recognition of those mothers "at risk" of postnatal depression was discussed. Secondly, the health visiting technique of "searching" for health needs was among the principles of health visiting formulated by the CETHV (1977). This technique was observed during the six-month home visit and it's effectiveness was assessed. The third area of investigation concerned the health visitors' perception and professional opinions about which mothers developed postnatal depression during the year after childbirth. There were differences of opinion between the health visitors and mothers about these developments and reasons for these were suggested in further analyses.

In the last section of this chapter there is a discussion about the health visitors' knowledge of the mothers' community network systems as well as other aspects of health visitors' intervention and care such as the mobilisation of available resources.

8.2. THE HEALTH VISITORS' CONTACT WITH THE MOTHER

All health visiting contacts with mothers could have provided opportunities for health promotion and preventive health care.

Antenatal Contact

The present system of antenatal care in the United Kingdom, includes clinic visits in Family Practitioners' surgeries, Health Centres and Maternity Hospitals, but not much contact between health visitors and the pregnant women, and this was so in Portsmouth Health District. Perhaps this situation had developed because health visitors are not required to have midwifery experience (they only require four months obstetric experience). On the other hand there are occasions where health visitors and midwives have established working

relationships that have enabled health visitors to make routine antenatal visits and to also contribute to antenatal health education classes. The health visitors' limited antenatal involvement in Portsmouth Health District was one reason for restricting the current study to postpartum depression.

In the district there were health visitors who routinely contacted all the pregnant women for whom they would care after childbirth. On other occasions they may have met at antenatal or mothercraft classes (see next section). Table 41 shows when the health visitors and mothers first met and any antenatal contact; it can be seen that 23 (21%) out of 110 depressed and 20 (21%) out of 94 non-depressed mothers met their health visitor for the first time during the antenatal months. If the pregnant woman had other children, it was quite possible that the health visitor already knew the family and had routine contact during this time because there were pre-school children, in the present study this was so for 26 (24%) of the 110 depressed mothers and 22 (23%) of the non-depressed mothers. There were however three mothers (4%) of the 94 non-depressed mothers who had a pre-school child and were known to their health visitors but had no ante-natal contact.

The health visitors first met 61 mothers (55%) of the depressed group and 49 (52%) of the non-depressed group after childbirth. The figures in this table showed very little difference between the depressed and non-depressed groups and suggested that antenatal contact between health visitors and mothers made no difference to the subsequent development of depression in mothers. This was a surprising result as there are frequent demands from the public and pressure groups such as National Childbirth Trust for mothers to have more contact with health visitors antenatally, so as to reduce the incidence of postnatal

depression. Perhaps what is more important is the type of care the health visitors provide during this contact, for example whether the health visitors take these opportunities to discuss the mothers' feelings.

TABLE 41

HEALTH VISITORS FIRST MEETING WITH MOTHERS

First Meeting	Mothers			
	Depressed		Non-depressed	
		%		%
More than a year before childbirth	26	24	22	23
More than a year before childbirth- no antenatal contact	0	0	3	4
During this pregnancy	23	21	20	21
After birth of this baby	61	55	49	52
Total mothers	110	100	94	100

Source: Health Visitors Recording Schedule 1.

Antenatal and Mothercraft Classes

As mentioned above, health visitors may meet mothers (or both mothers and fathers) at antenatal or mothercraft classes. These classes may be organised by the midwife or health visitor or both, to provide information and anticipatory guidance about childbirth and parenting.

This study did not ask who organised these classes, but it did question whether the mother attended. Table 42 shows that, of the mothers suffering depression, considerably more had attended mothercraft

classes than those who had not; although the difference was not statistically significant (X^2 = 2.5, with 1 degree of freedom; p ns), it requires comment. Perhaps the differences can be explained in part by noting that the aim of these classes is to prepare mothers for motherhood and most of the mothers who attend are having their first baby. Although multiparous women are not excluded from the classes, in most instances attendance, particularly if accompanied by small noisy and energetic children, would have been difficult to handle. It has been shown (Chapter 6, "Number of Children") that 60% of the depressed group and slightly less of the non-depressed group were primiparous. Therefore there was probably a slightly higher proportion of primiparous mothers in the depressed group attending mothercraft classes.

It is well known that mothercraft classes do not attract all expectant mothers, and many researchers (eg Rees, 1981) have tried to find out why, usually looking at the question of how the classes have been presented. However it is also possible that it is the more anxious mothers who attend; or those who are most likely to develop a subsequent postnatal depression.

TABLE 42

MOTHERS' ATTENDANCE AT MOTHERCRAFT CLASSES

Attendance	Mothers			
	Depressed		Non-depressed	
		%		%
Yes	49	45	32	34
No	61	55	62	66
Total Mothers	110	100	94	100

Source: Health Visitors' Recording Schedule 1.

Postnatal Contact

The difficulties in following up mothers who had moved house and had a change of health visitor during the year were mentioned in the sample response in Chapter 5; a number of new health visitors felt unable to complete the Health Vistors' Recording Schedule 2 because they did not know the mothers, therefore these mothers could not be kept in the sample. However it was found that of the mothers who were followed up, the depressed group had had fewer changes of health visitor than the non-depressed group. There is no obvious reason for this except that those who were not followed up differed in someway, such as being more mobile or more independent etc.

It was obviously important to ascertain the number of meetings between mothers and the health visitors. These are shown in Tables 43 and 44 which refer to meetings on an individual basis, but exclude phone calls and meetings on a group basis. It will be seen from Table 43 that the median of meetings was 13, the same for both the depressed and non-depressed mothers: there was, however, a difference at the upper end of the distribution, as 26 (24%) of the 110 depressed mothers, had more than 20 contacts with their health visitors as compared with only 14 (14%) of the 94 non-depressed. The somewhat higher rate of contact for the depressed mothers may have indicated a response to the mothers' difficulties. Table 44 shows the total contact between the mothers and "other health visitors"; the latter were not directly responsible for the care of the mothers, but may have met them in clinics, or at home whilst the responsible health visitor was on sick or ordinary leave. When the responsible health visitor had changed during the year, the earlier health visitor' contacts were included in Table 44 as "others"

contacts; there was an average of 5 contacts for each mother in this category.

TABLE 43

CONTACT BETWEEN MOTHERS AND HEALTH VISITORS RESPONSIBLE* FOR THEIR CARE

Number of Contacts	Mothers				
	Depressed			Non-depressed	
Home Visits and Clinics		%			%
0	2	3		4	4
1-5	12	11		9	10
6-10	27	24		17	18
11-15	27	24		32	33
16-20	16	14		18	18
21-25	9	8		9	9
26-30	12	11	24%	3	3	14%
31+	5	5		2	2
Total Mothers	110	99		94	99
Median	13			13	

* Those health visitors who were responsible for providing health visiting care to the mothers when the information was collected in Health Visitors Recording Schedule II.

TABLE 44

CONTACTS BETWEEN MOTHERS AND "OTHER"* HEALTH VISITORS

Number of Contacts Home Visits and Clinics	Mothers			
	Depressed		Non-depressed	
		%		%
0	32	30	32	34
1-5	41	37	34	36
6-10	16	14	13	14
11-15	9	8	6	6
16-20	4	4	7	7
21+	8	7	2	2
Total Mothers	110	100	94	100
Median (omitting 0)	5		4	

*Excluding the health visitors responsible for the mothers' care described in Table 43)

Source: Health Visitor Recording Schedule 2

When the home visits and clinic contacts were separately analysed, significant differences were noted in the home visiting patterns.

It could be said that the health visitors were responsible for facilitating meetings with mothers in clinics, by ensuring these attendances were positive experiences for mothers. Some doubt that this happens is reflected in Graham and McKee's work (1980). Nevertheless the actual attendance at clinics was largely dependent upon the mothers' motivation and mobility. Interestingly, in the present study, the clinic attendances of the depressed group of mothers were not higher than those for the non-depressed group. Perhaps this is explained by Warner's work in 1983; she suggested that health visitors did not give

mothers an opportunity to talk about themselves during their clinic contacts, possibly because of time limitations and the pressure of waiting clients. Home visits have a different emphasis from clinics, because the actual home visits depended upon the health visitors' availability rather than the mothers' motivation. The Health District had Guidelines suggesting a minimum number of home visits, and in addition the mothers could have asked health visitors to visit them at other times. There is no current evidence to prove that the health visiting care provided for mothers in their own homes is superior to that provided in clinics, although this is implied by the district guidelines and discussed in Thinking about Health Visiting (RCN, 1983).

TABLE 45

HOME VISITS BETWEEN MOTHERS AND HEALTH VISITORS RESPONSIBLE* FOR THEIR CARE

Number of Home Visits	Mothers			
	Depressed	%	Non-depressed	%
0**	8	8	3	3
1-5	49	44	58	62
6-10	31	28	31	33
11+	22	20	2	2
Total Mothers	110	100	94	100
Median	5		5	

* Those health visitors who were responsible for providing health visiting care to the mothers when the information was collected in the Health Visitor Recording Schedule 2's.

** All mothers in this group received some home visits from health visitors, but from others rather than those responsible for their care.

Although there was an average of 5 home visits to all mothers, many in both groups (depressed and non-depressed) received up to 10 home visits. However those receiving more than ten visits were almost entirely to be found among the depressed group. The quality of all this contact is unknown; the author does not know whether health visitors raised the subject of the mothers' feelings or discussed them in any other way. It is also unknown whether the extra visits averted depression in the few mothers who reported no depression, or whether the mothers receiving the most visits became depressed in spite of the extra attention! The author believes that the health visitors most probably perceived the mothers' needs, and provided support and therapy for the depressed mothers and their families during the extra home visiting. This was confirmed in the Mothers' Questionnaires by a number of mothers spontaneously mentioning the support that they had received from the health visitors.

'Other' health visitors also averaged five home visits to both groups of mothers; all mothers who received more than five home visits from 'other' health visitors were in the depressed group, as shown in Table 46. It will be seen in Table 45, that some mothers in each group were said to have received no home visits from their "responsible" health visitor, however they had all been visited at least once by another health visitor, and these visits are included in Table 46.

TABLE 46

HOME CONTACTS BETWEEN MOTHERS AND "OTHER" HEALTH VISITORS

Number of Home Visits	Mothers			
	Depressed		Non-depressed	
		%		%
0	74	68	67	72
1-5	29	26	26	28
6+	7	6	0	0
Total Mothers	110	100	94	100
Median (omitting 0)	3		3	

* Those health visitors who were responsible for providing health visiting care to the mothers when the information was collected in HVRS II.

** 'Others' excluded the health visitors described in Table 45

Having discussed the clinic and home contacts between health visitors and mothers, it is revealing to refer back to Chapter 6, Tables 37, 38 and especially 39. One of the most interesting points arising from these tables and the related discussion concerned the number of mothers prepared to ask doctors and health visitors for help with their problems, especially as more depressed than non-depressed mothers said they would do so. In fact, Table 38, in the present study showed that 28% of the depressed mothers had or would approach health visitors and ask for help with their own problems. It would seem that this experience was more positive than that studied by Orr (1978) who found that mothers thought that health visitors would be able to help with postnatal depression if they were asked, but few mothers expected to do so.

8.3. THE HEALTH VISITORS' RECOGNITION OF MOTHERS "AT RISK" OF INCIPIENT POSTNATAL DEPRESSION.

The recognition of persons "at risk" of a health problem is an essential part of health visiting care and one of the principles recognised by the CETHV in 1977. Therefore because health visitors receive a training in which the psychological aspects of childbearing are emphasised, the recognition of postnatal depression should be an important part of their work. Information to aid the health visitors' recognition of those mothers "at risk" of postnatal illness and particularly depression is acquired in a variety of ways. Most health visitors in Portsmouth Health District were members of a Primary Health Care Team, and should have been able to gather information concerning the sociological, physiological and psychological history of the mothers from other team members, particularly the midwives, the family practitioners or the mothers themselves. There may have been indicators in the available information that would have suggested a potential postnatal depressive illness such as a previous depression or bereavement; many of these indicators were discussed in Chapter 6, in the section about associated psychosocial factors.

Information from the Midwife

Close teamwork was possible between community midwives and health visitors particularly where they were both members of the same primary health care team. The midwives normally observed the mothers before and after childbirth, and may have noticed the way the mothers responded to the process of change, especially where the mother's responses to the changes were abnormal. If such information were shared with the health

visitors it might have enabled more adequate health visiting care, especially in the early recognition of those "at risk" of postnatal depression.

In the present study midwives were asked to share with the health visitors their opinions about which mothers they believed to be "at risk" of postnatal depression. The community midwives had frequently known the mothers antenatally, but most deliveries took place in the hospital and the mothers were then cared for by hospital midwives. A few days after delivery the community midwives again took over the care of the mothers, and would have been given relevant information about the mothers' mental and physical health during labour and early puerperium by the hospital midwives.

It was possible for the health visitors to have received all the above collective information from the community midwives either verbally or on "the obstetric transfer report"; in the present study the latter also included information about those mothers the midwives thought to be "at risk" of postnatal depression. The health visitors recorded the available information in the Health Visitors Recording Schedule 1.

The analysis of the midwives' information revealed many occasions when the midwives did not know whether the mother might develop postnatal depression. The last finding was slightly ambiguous as it could have included many occasions when the health visitor had received no information from the midwife and so did not know what to record in HVRS 1. The conclusions drawn from the received, and recorded information, are shown in Table 47 which compared midwives' opinions with those of the mothers at the end of the year (namely the 110 depressed and the 94 non-depressed mothers, a total of 204 mothers).

TABLE 47

MIDWIVES' REASONS FOR THINKING THAT MOTHERS WERE "AT RISK" OF DEVELOPING POSTNATAL DEPRESSION

Reasons	Mothers				Totals
	Depressed	%	Non-Depressed	%	
Previous postnatal depression or depression	4	4	2	2	6
Puerperium difficulties	2	2	0	0	2
Mother's anxiety	12	12	2	2	2
Mother's relationship with baby	2	12	2	1	14
Mother's relationship with husband	1	1	1	1	3
Husband away	3	3	0	0	3
Total responses	24		6		30
Mothers at risk	17	15	5	5	22
Mothers not at risk	93	85	89	95	188
Total mothers	110	100	94	100	204

The midwives had thought 22 of the 204 mothers would become depressed (just under 11%). In fact 17 of these 22 mothers said that they became depressed and five said that they did not, which indicated that midwives perceived the situation correctly for 15% (17 of 110 mothers) of the depressed mothers. Although the midwives seriously

underestimated the numbers who might become depressed, they were in fact highly accurate with those they did predict - 17 out of 22 or 77%. It was also to their credit that they did not overestimate to any marked extent as only 23% of those they regarded as being "at risk" did not in fact develop postnatal depression.

As shown in Table 47 the midwives based their judgement very largely on two main sources of evidence - the mothers' level of anxiety while in their care, and a history of depression whether postnatal or otherwise. This finding was consistent with those of Kumar (1982). Generally speaking it can be seen from Table 47 that the correct predictions were predominantly based on factual observations - apparent anxiety, puerperium difficulties, absence of husband, and a previous clinical history.

The information the health visitors gathered from the family practitioner members of the primary health care teams is discussed in 8.6, in the section called Professional Support Systems. However it is likely that information from the mothers' family practitioners and also that from the mothers' contributed to the health visitors' opinions in the following paragraphs.

The Health Visitors' Opinions after the 'Primary Visit'

It was shown in Table 41 that health visitors met 55% of the depressed mothers and 52% of the non-depressed mothers for the first time after childbirth, at the "primary visit". Therefore, many health

visitors' opinions about whether a mother was "at risk" of postnatal depression were made after this, their first meeting, (although they may have had considerable information about the mothers' history from other sources, as mentioned in the previous paragraphs). This meeting would have been at a time when the mother was adjusting psychologically and physically, and to the physiological after effects of the birth process, and the demands of a new baby. Table 48 shows how the health visitors' opinions at this time compared with those of the midwives given in Table 47.

a. The health visitors agreed about 5 mothers (4 of these were in the depressed group),

b. they disagreed with the midwives about 10 mothers (7 of these were in the depressed group) and

c. they were unsure about 7 (6 of these were in the depressed group).

Although the above numbers are small there is an indication that health visitors would benefit from using the information gathered by the midwives about the mothers' anxiety; especially as the mothers may not have seemed depressed or anxious when the health visitors met them, and the mothers' anxiety that was observed by the midwives might have been a precursor to a subsequent postnatal depression.

Further analysis of the health visitors' opinions after the primary visit, omitted the midwives' opinions.

TABLE 48

THE MIDWIVES' REASONS FOR THE 22 MOTHERS "AT RISK" OF POSTNATAL DEPRESSION COMPARED WITH THE HEALTH VISITORS' OPINIONS ABOUT THE SAME MOTHERS, (AFTER THE PRIMARY VISIT).

Midwives' Reasons	PND Opinions of Health Visitor * Mothers					
	Depressed			Non-Depressed		
	Yes	No	Unsure	Yes	No	Unsure
Previous depression or postnatal depression	2	0	2	0	1	1
Puerperium difficulties	0	2	0	0	0	0
Mother's anxiety	2	6	4	1	1	0
Mother's relationship with baby	0	1	1	0	1	0
Mother's relationship with husband	0	1	0	0	1	0
Husband away	2	1	0	0	0	0
Total Responses (24)	6	11	7	(6) 1	4	1
Total Mothers: 'at risk'		17			5	
not 'at risk'		93			89	
Total Mothers		110			94	

* PND: The health visitors' opinions about whether the mothers were "at risk" of postnatal depression are categorised in the depressed and non-depressed groups of mothers.

Table 49 shows the health visitors' opinions after 'the primary visit', about which mothers were "at risk" of developing postnatal depression, and whether these mothers were ultimately in the depressed group or not. The health visitors' judgement at the two week visit was only fair. The percentages of mothers thought to be "at risk" in both groups were similar. They thought that 16 mothers would become depressed and only 10 (62%) did so, and these mothers made up only 9% of the total 110 depressed mothers. Uncertainty was expressed by the health visitors about another group of 44 mothers and 26 (42%) of these became depressed. The health visitors did not think a further 144 mothers would become depressed, whereas 73 or 51% of these mothers did.

All the information discussed in the above paragraphs was the professional opinion of the midwives and health visitors which was based on their own knowledge, experience and understanding of postnatal depression.

TABLE 49

THE HEALTH VISITORS' OPINIONS AFTER THE PRIMARY VISIT ABOUT MOTHERS "AT RISK" OF POSTNATAL DEPRESSION

Health visitors opinion -"at risk"	Mothers					
	Depressed	%	Non-Depressed	%	Total	%
Yes	10	9	6	6	16	8
Unsure	29	26	15	16	44	21
No	71	65	73	78	144	71
Total Mothers	110	100	94	100	204	100

The Health Visitors' Opinion Six to Eight Weeks after the Mothers' deliveries.

When the field work of the present study took place the District Health Authority guidelines did not suggest visiting during the 4 weeks after the primary visit. However there may have been a number of contacts such as interim home visits, or meetings at child health clinics, or mothers groups organised by the health visitors. During these four weeks many health visitors revised their opinions about which mothers would develop postnatal depression. In Table 50 it is shown that after their meetings with the mothers six to eight weeks post childbirth the health visitors' thought that:

a. 12 mothers in the depressed group (over 10%) had had postnatal depression since the 'primary visit'. Three mothers in the non-depressed group had experienced depression, but for periods too brief to satisfy our definition of 'depressed' for the purposes of the present study.

b. Five mothers in the depressed group (4%) were currently depressed.

Interestingly, when this information was collected six weeks after childbirth only two of the 15 mothers (i.e. 12 in the depressed and three in the non-depressed group) noted by the health visitor to have already been depressed had seen their family practitioner about the same problem; nevertheless three-quarters of these 15 mothers received extra home visits from the health visitors during the postnatal year.

TABLE 50

HEALTH VISITORS' OPINIONS AFTER THE SIX WEEK VISIT

Mothers with postnatal depression	Mothers			
	Depressed		Non-Depressed	
		%		%
Had PND between delivery and 6-8 week visit	12	11	3	4
Suffering with PND at 6-8 weeks	5	4	0	0
No comment	85	80	91	96
Total mothers	110	100	94	100

*Reasons for further eight mothers 'at risk'		8	5	1	99
Previous depression	3				
Mothers' anxiety	5				
Mother unwell	2				
Life events	8				
Marital problems	1				
No available family	2				
Total Reasons for eight mothers	(21)				

* New mothers "at risk" were in addition to those mentioned after the primary visit.

The health visitors' revised opinions after their six to eight week contact with the mothers also indicated that they thought that an additional nine mothers had become "at risk" of developing postnatal depression; eight said that they had been depressed (7% of the depressed group) and one mother had not. The reasons the health visitors gave for thinking the eight mothers (who became depressed) were

"at risk" are shown in Table 50; three mothers who had had a previous depression were thought to be 'at risk' of postnatal depression. It appears from the above Tables 49 and 50 that during the first few postnatal weeks health visitors did not anticipate postnatal depression in the majority of mothers who suffered from the problem during the postnatal year. This was despite the fact that at this time other primary health care team members, namely the midwives and family practitioners would also have been working with the mothers and as mentioned earlier the health visitors probably gained further knowledge about the mothers from these team members.

There were two versions of the Health Visitor Recording Schedule 1, Section c: the regular and shortened. The questions in the regular version provided many cues for the health visitors regarding the mothers' emotional health. It had been hoped to compare the regular and shortened versions to ascertain whether the cues in the regular version enabled health visitors to make more informed decisions about potential mothers "at risk" of postnatal depression; unfortunately as the health visitors noted only few 'at risk' mothers this analysis was not possible. The author had thought that health visitors would have developed an ability to predict postnatal depression, so it was disappointing that this could not be confirmed in the above results.

8.4. SEARCHING FOR HEALTH NEEDS

The health visitor's "search for health problems" is one skill particularly relevant in their role in secondary prevention:

> "The search is an active, deliberate looking for acknowledged and unacknowledged health problems, but is constrained by ethics and client participation" (CETHV, 1977a).

Although the health visitor's search has seldom been investigated, it was an implied part of Luker's study (1982) which evaluated health visitors' practice with the elderly.

The methods of observing and tape recording the health visiting "techniques" were discussed in Chapters 4 and 5 but a short summary is given below. Seventeen health visitors were accompanied on routine home visits to a total of 62 mothers, six months after childbirth. The health visitors were observed carrying out the functions of their visit, after these were completed the author asked further questions. These visits were tape-recorded and, despite a few poor recordings, 43 were transcribed and analysed. A special attempt was made to include in these 43 transcriptions those mothers who said that they had been depressed (the depressed group) and those whom the health visitors had said had either been "at risk", or had been depressed.

The home visits six months after childbirth are recommended particularly to observe the developmental attainments of the baby. It is known that babies require a healthy environment for normal development and one of the most important factors in this environment is a healthy mother, or mother substitute. It was therefore expected that health visitors would have enquired about the mothers' physical and psychological health at some time during this visit.

The tape recordings confirmed the observations that for the greater part of most visits the health visitors spoke to the mothers about their babies. Curiously the health visitor discussed the mother's health first in only two out of the 43 transcribed visits. On both these

occasions the health visitor had only recently become responsible for the mother's health visiting care, and only met the mother at this visit for the first time. Perhaps the other health visitors knew the mothers well by the time of the visit, and preferred to concentrate on the babies' developmental attainments. It is nevertheless more likely that the observations made in this study confirmed the emphasis on children's care as the health visiting priority. All occasions where health visitors allowed mothers to talk about their feelings were noted in detail, they are shown in Table 51, and are summarised below.

There were some health visitors without prior knowledge of mothers' depressive feelings, who encouraged mothers to talk about themselves. In this group there were eight mothers who expressed depressive feelings and nine who did not (one of these nine said she had been very depressed after the author asked more direct questions).

Other health visitors knew the mothers had been depressed, or currently felt so. In this group the health visitors raised the subject for discussion offering eight mothers further opportunities to talk about their distress and unhappiness.

A few health visitors knew of no depressive feelings and did not create opportunities for mothers' discussions, but six mothers offered cues. Health visitors picked up the cues for three of these six mothers. (The other three mothers talked about their depression when given the opportunity by the author.)

In the last group there were 13 occasions where health visitors neither searched nor created opportunities for the mothers to discuss their feelings, and the mothers gave no cues. When the author created opportunities for the mothers to talk about themselves nine said they were, or had been, depressed and only four had not.

TABLE 51

HEALTH VISITORS' "SEARCH" FOR FEELINGS

AND SYMPTOMS OF DEPRESSION IN MOTHERS*

Health Visitors' Technique	Mothers with Feelings or Symptoms of Depression		
	Yes		No
	Feelings and Symptoms exposed by:		
	Health Visitor	Author	
1. Without prior knowledge, encouraged mothers to talk	7	1**	8
2. With prior knowledge encouraged mothers to talk	8	0	0
3. Mothers spontaneously offered cues, health visitors' response:			
a. Listened	3	0	0
b. Did not listen	0	3	0
4. No health visitor search and no cues from the mothers	0	9	4
Total Mothers	18	13	12
		31	12
	43		

* Only 43 of the 62 visits were transcribed and analysed.

** This mother first told the health visitor she had no feelings of depression etc. She was very depressed.

The above sample of health visitors and mothers was highly biased to include mothers recognised, 6 weeks postnatally, as "at risk" of depression by these same health visitors.

8.5. THE HEALTH VISITORS' OPINIONS AT THE END OF THE YEAR.

The mothers in the study met their health visitors on an average of 13 occasions in the postpartum year as mentioned earlier in this chapter. At the end of this year the health visitors completed the Health Visitor Recording Schedule 2, and reported whether in their opinion the mothers had had postnatal depression during this time. The health visitors said that they thought a total of 39 mothers had been depressed for two weeks or longer. Seven of these mothers did not return their own questionnaire (MQ), possibly because of this depression. A further five said that they had not felt depressed for weeks or longer; two said they had been depressed for a few days only and the other three claimed no depression (Table 52). There were considerable differences between the health visitors opinions and those of the mothers, as is shown in Table 52; the health visitors recognised only 27 of the 110 depressed mothers (25%, the 95% confidence interval =17% to 33%). Possible reasons for these differences will be covered in the following paragraphs.

TABLE 52

MOTHERS* THOUGHT BY HEALTH VISITORS TO HAVE HAD POSTNATAL DEPRESSION

Health Visitors	Mothers				
Opinions	Depressed		Non-depressed		No MQ
		%		%	
No	83	75	89	95	-
Yes **	27	25	5	5	7
Total Mothers	110	100	94	100	

Source: Health Visitors' Recording Schedule 2

* This table includes mothers from the depressed and non-depressed groups, and also the seven mothers not categorised as they did not return their questionnaires.

** Health visitors thought that certain mothers had been depressed during the first six to eight weeks postpartum; during the analysis it was noted that the health visitors had not included all these mothers in the 39 mothers mentioned in this table (27 depressed, 5 non-depressed and 7 with no mothers' questionnaire). It was not possible to establish how many of the excluded mothers might have fitted the definition of postnatal depression used in this study.

At the six to eight week interview only seven of the above 27 (or 26%) depressed mothers, were noted by health visitors to have already had postnatal depression since their deliveries and a further four of the above 27 (or 15%) mothers were thought to be "at risk", at that time. Therefore it appears of the 27 mothers whom the health visitors said had been depressed during the year, 16, or 59%, were not thought, within the first six to eight postnatal weeks, to be "at risk" of postnatal depression in the future. Similarly unnoticed at this stage were no fewer than 99 of the 110 depressed group of mothers. This is an important point, suggesting that additional care given in the first six to eight postnatal weeks, does not necessarily include a careful monitoring of the mothers' emotional health, many cues are probably missed and incipient postnatal depression is not detected.

The Health Visitors' opinions about the length of the mothers' depression.

In Table 53, the health visitors opinions, about which mothers were depressed, were compared with the mothers' own opinions of the duration of their depression .

TABLE 53

DURATION OF DEPRESSION AS SEEN BY MOTHERS AND HEALTH VISITORS

Mothers' statement on depression length	Mothers (1)	Depressed in HVs' opinion (2)	Column 2 as a % of Column 1
Up to 2 months	48	9	19
Longer	40	13	32
More than a year	7	3	42
Occasional days throughout the year	15	2	13
Total mothers	110	27	25

The longer the mother was depressed the greater the likelihood that the health visitors knew, but even so the health visitors recognised very few depressed mothers in each group, as shown in Table 54. The health visitors recognised 9 of 48 mothers (19%) depressed under 1 month, 13 of 40 mothers (32%) depressed for months, 3 of 7 mothers (42%) depressed for more than a year and 2 of 15 mothers (13%) depressed for periods of days throughout the year.

There is a debate (Kumar, 1982) about the hormonal influences and the pre-menstrual syndrome (Dalton, 1980) leading to a depression lasting for a few days, at regular intervals throughout the year. It will be noted in Table 53 that despite the available and publicised information about possible hormonal influences, (Kumar, 1982 and Dalton, 1980) few of the health visitors noted the cases of periodic depression.

The findings about the health visitors perception increasing with the length of the depression is quite understandable with the current

practice of health visiting, as the health visitor may not have met the mother during her depressive period, especially if it lasted for only a few weeks. However it is surprising that the depressive information was not transferred when they did meet, in fact this failed to happen in over 50% of the cases. Was this because the health visitors did not give the mothers the opportunities to talk about their feelings? Conversely, if the mothers no longer required help they may not have wanted to discuss the subject.

On the occasions when the health visitors were in agreement with the mothers about their depression, there were differences of opinion about its length; 10 mothers said that their depression was shorter and 14 said that it lasted a longer time than the health visitors had thought, although the differences were not statistically significant.

The health visitors' opinions about the onset of the mothers' depression.

An analysis of the health visitors' recognition of the depression by when the mothers said that the depression began is shown in Table 54.

Interestingly, although 59 mothers reported that their depression began in the first few postnatal weeks the health visitors only recognised 12 (21%) of these mothers. This was surprising especially as health visitors definitely have at least one contact at this time, viz the primary visit, and in the present study they also had contact at the 6 week visit.

TABLE 54

ONSET TIME AS SEEN BY

MOTHERS AND HEALTH VISITORS

Onset in months after childbirth	Number of mothers (1)	Depressed in HV's opinion (2)	Column 2 as a % of Column 1
0-2	59	12	21
3-6	21	10	48
6+	15	3	20
Total mothers	95*	25	27

* 95 depressed mothers, the 15 mothers depressed for occasional days throughout the year have been excluded from this table.

During the primary visit, the health visitors, when introducing themselves to the mothers (and family), presumably describe their role in preventive health care. In doing so, they would encourage the mothers to use the service as needed, in addition to the planned routine health visiting. As mentioned previously perhaps health visitors understand a mothers' anxiety and depression in the first two months after childbirth as a natural process of adjustment; it is also possible that health visitors felt it was inappropriate and undesirable to give this process of adjustment a psychiatric label. Perhaps health visitors have found from their experience that most of these mothers get better without a diagnosis. It is not known whether any damage occurs to the mothers' relationships with their babies, husbands and families during this process. The finding that only two mothers, depressed at this time, saw their family practitioners about their depression in these early weeks, suggests that a depression in the early postnatal weeks is thought by the mothers themselves to be a normal process of

adjustment.

It was interesting to note, in Table 54, the 48% agreement when the depression started between 3 to 6 months postpartum; health visitors are often in close contact with families at this time, as it is a period when mothers may require advice on infant feeding and immunisation procedures. The accordance dropped again to 20% when the mothers said that their depression commenced in the second six months of the year, a probable explanation is that during this time of the year health visitors normally have less contact with mothers and their babies. These results suggest that the health visitor - mother contact times revolve around children's needs more than mothers'.

The length of the mothers' depression has been discussed in some detail as was the contact between the health visitors and mothers in an earlier section. This was because there may have been an association with the recognition of the problem and the pattern of health visiting; in the health district which had been based on the guidelines developed from reccommendations by Court (1976), CETHV (1977a) and Henderson J. (1977).

It should be noted that at the time of this study, the health visitors in the district in which the field work took place kept records mainly about the children; nevertheless there were additional recognised methods of recording information about other members of the family. However in the present study, the author looked at the health visitors' records kept for the families of those mothers who were observed at the 6 month home visit, and found few references to mothers. In a number of instances it was particularly revealing to find no information at all in the records even after long interviews had taken place, during which the mothers' feelings of anxiety and depression had been discussed at

length. Perhaps this was related to the health visitors' concern about confidentiality, but it is more probable that health visitors believed that their care should be directed to children, as their prime target, and only to mothers in passing. It would appear that the health visitors in the present study might have thought the mothers' emotional health that was discussed during the observed home visit was only of interest to the author, and did not come into their own health visiting care.

Since the fieldwork of the present study the nursing process method of recording health visiting care has been introduced into the district (Rogers, 1982). These new methods require a record of the health care given to the family, as well as the health care given to children.

The Health Visitors' recognition of postnatally depressed mothers who had had a previous depression or postnatal depression

There were 34 mothers in the depressed group of 110 mothers who had had a previous depressive episode or postnatal depression. These episodes were recorded by the health visitors on the HVRS 1. Most mothers with a history of depression became depressed after childbirth in the present study and the majority were recognised by the health visitors. This is an important point because the health visitors had not thought all these mothers were "at risk" of postnatal depression. Health visitors thought that only 10 of the 110 depressed mothers were 'at risk' of depression and they were unsure about a further 29 mothers, as was shown in Table 49. Therefore it would appear that it is very valuable for health visitors to have information about mothers' previous emotional health and the health visitors should subsequently use this

information for assessing the mothers' vulnerability to postnatal depression and for planning appropriate care.

The Mothers' Symptoms of Depression as described by the Health Visitors

The health visitors perception and knowledge, of the mothers' postnatal depression has already been reflected in a number of ways, such as recognising those "at risk" of becoming and those who became depressed, and shown to be rather limited. Their knowledge was also shown by their reported observations of the 27 postnatally depressed women; the information for this last finding was gathered in Health Visitor Recording Schedules 2, from the structured questions 14 - 19 (Appendix I); the health visitors were encouraged to provide additional information with their answers.

The depressive symptoms that the health visitors observed most commonly in the mothers were their attitudes towards themselves, their husbands, other people and their own babies. These and all other symptoms observed and recorded by the health visitors are shown in Table 55. As the health visitors' descriptions of these symptoms highlight their understanding of the mothers' problems, a few of their descriptions of the symptoms are also included below.

TABLE 55

DEPRESSIVE SYMPTOMS NOTED BY HEALTH VISITORS

Symptoms	Mothers with Symptoms	%
Mother's Attitudes:		
to herself	24	89
to husband	17	63
to others	16	59
to baby	11	41
Sleep	14	52
Weight	8	30
Other problems*	12	44
Mothers with symptoms noted	27	
" " " not noted	93	
Total Mothers	110	

* Other problems included:
mother's neglect of herself, home and family (6 mothers),
abnormal behaviour (4 mothers),
excessive tears (2 mothers), and
too dependent upon maternal grandmother (1 mother).

THE HEALTH VISITORS DESCRIPTIONS OF THE MOTHERS SYMPTOMS

1. Mothers' Attitudes to Themselves

The health visitors said:

7 mothers were unsure of their abilities,

5 mothers were unable to cope,

4 mothers were not interested in themselves,

3 mothers were very self-critical,

2 mothers were very inadequate,

1 mother was full of self-pity, and

2 mothers felt lonely.

2. Mothers´ Attitudes to their Husband

The health visitors noted:

6 couples had sexual problems,

3 couples could not communicate with each other,

2 mothers displayed aggressive behaviour towards their husbands, and

3 husbands lacked understanding of their wives feelings

3. Mothers´ Attitudes to Others

The health visitors said:

6 mothers had poor relationships with everybody,

4 mothers were excessively critical of their family,

3 mothers showed excessive anxiety about their family,

2 mothers were overdependent on the health visitor, and

1 mother was very rude to the health care professionals.

4. Mothers´ Attitudes to their Babies

The health visitors mentioned:

4 mothers had a strained relationship with their babies,

4 mothers who were very anxious about their babies´ health, and

3 mothers who lacked confidence in caring for their babies.

Interestingly, health visitors reported no aggressive feelings towards the baby but in the client diaries a number of mothers

(depressed and non-depressed) described aggressive feelings towards their babies or other children (refer to Chapter 7).

5. Sleeping Difficulties

The health visitors observed:

5 mothers who found difficulty in getting to sleep,

7 mothers with a poor sleeping pattern (2 of these were exacerbated by mismanagement of their babies) and

1 mother who woke early and could not get back to sleep.

Difficulty in sleeping was the only depressive symptom observed by health visitors that could be compared with symptoms described by the mothers themselves in Chapter 6, and the health visitors and mothers were in only 50% agreement.

The other problems that health visitors mentioned included mothers' abnormal behaviour, neglect of their families and excessive maternal crying.

Reasons for Different Opinions

There was a suggestion earlier in this chapter that the health visitors may have thought a mother's depression in the early weeks after childbirth was the normal adjustment to the birth process. The author thought that at other times in the year the postnatally depressed mothers or their children might have had health problems which required extra health visiting care; the focus on these particular problems might have hidden the mothers' postnatal depression or delayed it's recognition. Occasionally this happened, as shown in Table 56, but not

often enough to explain the perceptual differences between the mothers and health visitors, especially as health visitors did not express any concern about 67 of the 110 depressed mothers (61%).

TABLE 56

HEALTH VISITORS REASONS FOR GIVING

DEPRESSED MOTHERS EXTRA CARE

Problems perceived by Health Visitors	Depressed mothers	%
Mother pregnant again	2	2
Sick baby or feeding problems	5	4
Unconfident mother	3	3
Multiple family problems	2	2
No specific reason given	4	3
Mothers: receiving extra care	16	14
receiving no extra care	67	61
Postnatally depressed	27	25
Total mothers	110	100

The health visitors said that they had given extra health visiting care to 16 of the 110 mothers (14%) in the depressed group; five of these mothers received extra care because they had had problems with their babies, and another three because they were rather unconfident about their mothering abilities. All the mothers the health visitors recognised as depressed are also included in the above Table, although they did not necessarily receive extra health visiting care (as shown in Appendix O, pp 021).

8.6 THE HEALTH VISITORS' KNOWLEDGE OF THE MOTHERS' COMMUNITY SUPPORT SYSTEMS

The health visitors supplied the information in Table 36, Chapter 6, which showed which persons were available to help the mothers around the time of their confinements. This information indicated that health visitors had some knowledge about the mothers' community support systems at that time. Health visitors also supplied information about the mothers' participation in group activities during the postnatal year, as shown in Table 57.

TABLE 57

HEALTH VISITORS' KNOWLEDGE OF

MOTHERS' PARTICIPATION IN GROUPS

Health Visitors knew about Group participation	Mothers			
	Depressed	%	Non-depressed	%
Yes	12	11	7	7
No	35	32	36	33
Unknown	7	6	2	2
Total mothers took part in groups*	54	59	45	41
not in groups	56	51	49	45
Total mothers	110	100	94	100

*All these mothers said that they had attended community groups and this is shown in Table 40.

At the end of the postnatal year the mothers themselves noted which community groups they had used during the year, as shown in Table 40.

This information can be compared with the health visitors' information or knowledge about the mothers' group participation (Table 57). It would appear from the comparison that the health visitors had limited knowledge of both the depressed and non-depressed mothers' participation in groups.

8.7 THE HEALTH VISITORS' WORK WITH THE MOTHERS' PRIMARY HEALTH CARE TEAMS

In many areas and districts in the United Kingdom health visitors and midwives are attached to family practitioner practices with the aim to provide a comprehensive primary health care service. However, even when not attached it is possible for liaison to occur between the midwives, health visitors, family practitioners and other members of the caring teams. In the district in which the present study took place most family practitioner teams had attached midwives and health visitors. It was therefore disappointing and surprising that the health visitors were not always aware when the mothers had been diagnosed as clinically depressed by the family practitioner. Perhaps if health visitors were informed they, with the family practioners could provide team care for the mothers and their families. As it was the health visitors did state that 23 of the 27 depressed mothers that they had recognised, had also had help from other health and social services personnel, which included the family practtioners; therefore suggesting that when the health visitors recognised the problem, they shared the mothers' care with other professionals.

SUMMARY OF THE FINDINGS IN THIS CHAPTER.

Up till 1982, little information existed regarding specific health care needs of postnatally depressed women. In the present study it had been hoped to gather information about the mothers' needs and the appropriate caring skills from the health visitors' records; in this regard all health visiting records for the 62 mothers observed during the home visit were scrutinised twice, 6 months postpartum, and again 1 year later. Unfortunately these records revealed very little information about the mothers, or associated health visiting skills; this was unexpected because many of these health visitors had discussed maternal problems.

One reason for the limited recording may have been the weekly compilation of health visitor statistics which emphasised contacts with children. Nevertheless the non recording may have been a further example of little health visiting concern for mothers. Perhaps the health visitors' giving priority to children's care excluded care to other members of the families. However, the mothers' central role in children's normal physical and emotional development surely emphasises the importance of including maternal care as a health visiting priority.

The health visitors recognition of only a small proportion (27 out of 110 mothers, or 25%) of the depressed group of mothers also complicated the description of caring skills. Fortunately, Snaith (1982) and Brandon (1983) both described the care postnatally depressed mothers required: (a) a search for and identification of the problem, (b) reassurance, (c) support by their families, health professionals and community, (d) possibly some practical help, and (e) sometimes medication. Consequently the health visiting care noted in this study was similarly categorised.

(a) Searching for actual and potential health problems is a particular health visiting skill; health visitors were observed searching for symptoms of depression in 24 out of 43 mothers. This was during observed home visits which were also tape-recorded. Six of the other 19 mothers offered the health visitors cues about their depressed feelings, and the health visitors subsequently made a search in three instances, however the health visitors did not do so for the other three, nor for a further 13 mothers who had not offered any cues.

(b) During the observed home visits, there was evidence that many health visitors listened to and reassured 18 out of 31 puerperally depressed mothers.

(c) Henderson S.(1977) described the concept of support as "the interest and concern transmitted and received during interpersonal transactions". He thought this was probably required by most individuals for mental health maintenance, especially during stressful situations.

Perhaps the support health visitors gave depressed mothers was indicated by the extra visiting given to 22 of the 110 depressed mother compared with only two of the non-depressed mothers, and also by the number of mothers who said they would contact the health visitors for personal help.

Evidence from the health visitors suggested they shared their supportive care of those mothers that they had recognised as postnatally depressed with other professionals, especially the general practitioner.

As health visitors have a responsibility for many families, they can only spend a small portion of their working time with depressed

mothers, therefore, the author thought that they had probably encouraged mothers to find additional support from other community sources. Both the health visitors and mothers were asked for information about the mothers' participation in community support groups. The findings showed that health visitors had limited knowledge of either the depressed or non-depressed mothers' group participation.

(d) The health visiting records and the information in the observed visits showed little evidence of practical health visiting help for these mothers. Interestingly, 90% of the 110 depressed mothers mentioned tiredness as a symptom of their depression. Therefore practical help to alleviate tiredness must be an important need for these mothers. This was not mentioned by health visitors, suggesting either another lack of concern or, as is far more likely, a great difficulty in providing appropriate help for tired mothers in contemporary society.

e) The findings showed that many of the mothers whose postnatal depression was recognised by the health visitors also received care from their family practitioners, but as mentioned in Chapter 6 few mothers received medication.

CHAPTER 9

DISCUSSION OF THE FINDINGS

9.1. SUMMARY OF THE STUDY

In the present study three hundred and eighty six mothers; their midwives, health visitors and family practitioners participated in an eighteen-month project, from the mothers' seventh antenatal month to their fifteenth postnatal month.

Information was collected about the mothers' emotional health, and the associated health visiting skills, particularly those of "searching" and "caring". The methods used for collecting the information included psychiatric screening tests, questionnaires, health visiting records, and observations and tape recordings of health visiting in homes. Two hundred and thirty five mothers actually completed the eighteen-month study. During this time 110 mothers (47% of 235 mothers) became postnatally depressed. Sixty four of these mothers (27% of 235 mothers) became depressed within the first six weeks postpartum.

Early in the year of the study, health visitors thought 12 of the 110 depressed mothers (11%) were "at risk" of postnatal depression. At the end of the year they had recognised only 27 (25%) of the 110 mothers who had suffered postnatal depression.

These findings indicated that postnatal depression was a significant community problem and not always recognised, nor searched for, by health visitors.

9.2. THE OBJECTIVES OF THIS STUDY WERE TO ASCERTAIN, AS FOLLOWS.

(a) The incidence of postnatal depression using various measurements.

(b) The duration of the depression, when it starts, ends and the associated symptoms.

(c) Whether health visitors could identify mothers who were "at risk" of developing postnatal depression, and whether they recognised all those mothers who suffered from this problem in the year following their confinements.

(d) What skills health visitors used to screen and identify these women.

(e) What preventive methods health visitors used for those mothers "at risk".

(f) What skills health visitors used to meet the needs of the women who had postnatal depression.

(g) Whether, or where the health visiting service should be improved in this area.

9.3. INTRODUCTION TO THE FINDINGS

The object of health visiting care is the promotion of health, and the early detection and assessment of the health needs of the people in the community. The health visitors have regular contact with mothers at a level where they might detect postnatal depression non-intrusively (without arranging additional meetings) or non-invasively (without subjecting the mothers to tests, such as psychiatric or physiological). Clearly with the latter ability and their opportunities for detecting postnatal depression they were the ideal people to gather information about the disorder. As a first step it was logical to use health visitors as well as other methods to collect information about postnatal depression in this study.

However at the same time information was gathered about the process of health visiting care given to these mothers. For example, how did health visitors "search" for postnatal depression in mothers?

Because of these points, namely using the health visitors to collect the information and assessing their health visiting care, the whole study was carefully designed around normal health visiting practice. Thus, the sample of mothers was random, as health visitors do not pre-select their caseloads. The stages when the information was collected matched normal health visiting contact times. Finally all the information gathered, except for the results of the psychiatric tests would normally have been available to health visitors from other members of the primary health care teams, the general practitioners, the midwives and the mothers themselves.

Robinson (1982) and Luker (1982) both claimed that few attempts had been made to estimate the relevance of health visiting to a particular

task, and it's outcome. This was not done in the present study as evaluating preventive techniques is complex; it would have been difficult to measure the efficacy of attempts to prevent postnatal depression, if they had been successful and no disorder had ensued. Nevertheless, because of the historical events outlined in Chapter 3, it was assumed that health visitors should be involved in the care of postnatally depressed women. The present study concentrated on this process of care, particularly as no other study, to date, had been concerned with the health visiting care of emotional health problems.

When the study began the care for postnatal depression had unclear boundaries. It had been hoped that this would have been clarified by the analysis of health visitors' records of the care given to these women. For reasons which are explained in the text, this was difficult, and eventually the health visiting care was considered according to Brandon's (1983) and Snaith's (1982 a) recommendations, although they were devised from clinical experience rather than research.

9.4. OBJECTIVE A. THE INCIDENCE OF POSTNATAL DEPRESSION USING VARIOUS MEASUREMENTS.

In Chapter 3 many references emphasised the importance of linking the appropriate health care to the health needs of the community (WHO, 1976; Owen, 1977, and RCN, 1982). Thus a description of health visiting care should normally start with a description of the health needs in the community, and this was done in the present study.

The incidence of postnatal depression was described and assessed by various methods, as follows.

The Family Practitioners' Diagnoses

At the end of a 15 month period postpartum the mothers' family practitioners stated that they thought 19 out of 161 mothers (12%) had been depressed during this time (they only referred a few of these mothers to psychiatrists). These results were higher than earlier findings by family practitioners, such as the 3% incidence of postnatal depression in studies by both Ryle (1964) and Tod (1964); however those practitioners are known to have included only the most seriously affected cases, many of whom required psychiatric assistance (Kumar, 1982). On the other hand the family practitioner diagnoses, which were recorded retrospectively in the present study, were much lower than the results found in Playfair and Gowers' prospective experimental study (Playfair and Gowers, 1981). The latter study involved 618 women using 64 family practitioners; in their sample 150 mothers (24.3%) had 3 or more symptoms of depression at about 3 months post childbirth, and 17 (2.75%) mothers required a psychiatric opinion.

In Chapter 6 it was noted that many mothers from both the depressed (37 out of 110 mothers, or 34%) and non-depressed groups (27 out of 94, or 29%) said that if necessary they would ask their family practitioners for help for themselves. This requires comment as mothers frequently say that family practitioners do not understand postnatal depression. One mother in the present study said:

> "I went to see my family practitioner to tell him I felt awful because I had put a pillow over my baby's head and nearly killed him".

Her doctor apparently said:

> "You are lucky to live in a civilised country, go home and make your husband's supper".

Not surprisingly the mother told the author that she had felt totally misunderstood. She also said:

"older doctors seem not to know or care about depression, especially of young mothers - the doctor's receptionist was the one who came and talked to me - that was all that was really needed -it did not cure but it made it all more bearable".

The Health Visitors.

Somewhat disappointingly the health visitors' proved only a little better at identifying postnatal depression than did the family practitioners. This was rather surprising as the health visitors might have been alerted simply by being asked to take part in the study, and they had been involved with the collection of information in the study from as early as two weeks after the mothers' deliveries. Furthermore they had probably had far more opportunities than the family practitioners for assessing the mothers' emotional health, particularly during home visits. Reasons for the health visitors' results will be discussed later in the chapter.

Screening Tests

Considerable care was taken to choose two psychiatric screening tests for use in the normal community, as was described in Chapter 4. The tests were used in the present study to find depressed mothers from one sample of 77 mothers at 6 -8 weeks postpartum.

The first was Pitt' Anxiety Test (PAT) which screened 18 out of 76 (24%) mothers as postnatally depressed six weeks post confinement (one of the 77 mothers in this sample was too depressed to complete the test). This was higher than the 10.8% Pitt recorded when describing his own study, but lower than the 34 (39%) mothers he found depressed out of the 89 mothers he interviewed. No statistical correlation was found between the author's results and those of Pitt. However Breen's (1975) findings of 11 postnatally depressed mothers out of 51 mothers (22%) in her

sample correllated statistically with the 24% in the present study.

In the second test, the Crown-Crisp Experiential Index, 18% of the same sample of 77 mothers were screened postpartum and found to be depressed. The latter test was used again 13 months postpartum and showed similar percentages of depressed mothers; only four of these mothers, or 9%, were scored as being depressed at both test times. Although the CCEI results are interesting the author decided they were not really an appropriate measure for postnatal depression in the present study. This was because there were no pre-pregnancy ratings for the mothers, therefore the results could have included mothers who were already depressed before delivery.

Perhaps screening tests are not really appropriate in work with postnatal women. Possibly Cox, Connor and Kendell (1982) had similar feelings as they stated:

> .... "the disadvantage of relying on total symptom scores as a measure of psychiatric morbidity in childbearing women is shown. This raises important theoretical and practical issues concerning the use of self-rating questionnaires in childbearing women which will be discussed in a subsequent paper". (Cox, Connor and Kendell, 1982, p116)

The author of the present study had originally thought that if Pitt's Test or the Crown-Crisp Experiential Index were good indicators of postnatal depression, and easily administered and scored, then it might have been possible for Health Visitors to use them routinely as a screening device. However Pitt's Anxiety Test and the Crown-Crisp Experiential Index only described mothers' depression at 6 weeks, or at 1 year and did not describe all those mothers who became postnatally depressed during the interim periods. Therefore, after using them in this study, it appeared that the tests had limited use and that there were probably simpler methods of identifying these mothers.

Mothers' Subjective Opinions

The author turned to the mothers' own subjective opinions about their depression, and when these fitted Pitt's 4 criteria the mothers were defined as postnatally depressed. This method has been described by Snaith as a fairly wide definition which may lead to estimates on the high side. However the author believed that in a normal community it was important to use a standard definition, which had been used by other researchers (Pitt, 1968 and Cox, Connor and Kendell, 1982), was based on the mothers' own opinions, and could be used by health visitors for assessing postnatal depression in mothers.

Using this method a large number of mothers, 110 of 235 (47%) mothers, were defined as having been postnatally depressed at some time in the year. For 64 of these 235 mothers the depression began within the first six to eight weeks post childbirth. These figures could not be compared directly with the 18 out of 76 mothers (24%) screened postnatally depressed on the PAT, nor the 13 out of 77 (18%) mothers screened depressed using the CCEI 1; this was because neither test included those mothers whose depression had remitted by the time of the tests. Nevertheless the three assessments (Pitt's 4 Criteria, PAT and the CCEI) showed a postnatal depression incidence ranging from 18-27%, within the first 6-8 weeks postpartum, as was discussed in Chapter 6.

Discussions about the High Incidence

Despite the care taken to gather information for this study non-intrusively, it was possible that the nature of the study, contributed to the higher incidence of postnatal depression than had been expected. However if the health visitors' involvement in the study

contributed to this high incidence, the findings showed that they were quite unaware of what they had stimulated. In contrast, Kumar thought that the added professional involvement with the mothers in his study had probably reduced the incidence of postnatal depression which he found.

Another possible reason for the high incidence in the present study could have been the connection between neuroticism and depression; they are known to co vary and therefore it was more likely that women who had been anxious or depressed would have completed the postal questionnaires and maintained their previous involvement in the study (Kumar, 1982, p 94).

The large incidence found in the present study could have been due to values currently held in a technological society, which encourage the concept of living without stress and tension. Unfortunately having and caring for a baby is stressful, tiring, and produces tensions, and therefore deviates from the above social and cultural value. British society believes that stressful feelings should be labelled as an illness, preferably by a doctor. Szaz believed mentally ill patients should be regarded as people with a problem of living (Miles, 1982); perhaps in postnatal depression the problem was adjusting to and living with a demanding baby.

Labelling

It is quite likely that certain mothers defined as postnatally depressed in this study did not think that they had been, and would not like to have been labelled in this manner, this is important and requires discussion.

Perhaps labelling a mother postnatally depressed may have far

reaching consequences. According to labelling theorists, the label may lead to secondary mentally ill behaviour, whereas without the label the original symptoms may be unimportant and may go unnoticed. This does not necessarily apply to postnatal depression, as the first step in helping a postnatally depressed mother and her family is to recognise the symptoms (Snaith, 1983). Instead of labelling a mother as postnatally depressed, it may be wiser to suggest that the mother is going through a difficult change process, which improves and resolves with the correct care.

Possibly health visitors also did not wish to give mothers a Postnatal Depression label, particularly as they only recognised 27 (25%) of the 110 depressed mothers. If health visitors had expressed any other concern about those mothers defined as depressed (but not thought so by the health visitors) this could have been assumed, but as discussed in Chapter 8 this seldom happened. It could also be argued that postnatal depression as defined in this study was so prevalent that the health visitors considered it was a normal part of motherhood. This certainly may have happened in the first 6-8 weeks postpartum when health visitors only recognised 12 (21%) out of 59 mothers on whom the health visitors had commented at that stage (see Table 54 in Chapter 9).

Certainly if virtually every second mother suffered from a bout of postnatal depression, the problem could have been disregarded and treated as a normal part of motherhood. Unfortunately as already noted, some mothers suffered for long periods, and the long term consequences might have been distressing and serious. Perhaps postnatal depression should be seen as a medico-social epidemic of modern society, deserving better descriptive studies and discussions of appropriate care. Bardon

(1983), a psychiatrist, in an open letter to the National Childbirth Trust certainly maintained that it was quite wrong to claim that postnatal depression was normal because it was common:

> "It is totally unacceptable for professionals to say as they are now starting to say, that depression after childbirth is normal. If by normal is meant "that which commonly happens" then there is something seriously wrong with today's management of childbirth and with attitudes..... If by calling depresssion normal the professionals are suggesting that it does not matter then they are speaking from ignorance...."

9.5. OBJECTIVE B. THE DURATION OF THE DEPRESSION, WHEN IT STARTS, ENDS AND THE ASSOCIATED SYMPTOMS

When postnatal depression starts.

This raises considerable interest and would be useful if known by the mothers, their families, their community support systems, and their health carers. Interestingly in this study a large proportion of the depressed mothers became depressed within the first 2 months after childbirth. This must have affected the early days of motherhood, as during this time the mothers and new babies would have been adjusting to each other; the mothers would also have been adjusting to other relationships, such as their husbands in their roles as fathers, for the first time, or with the responsibility of an additional child.

During these first few weeks mothers normally have had to feed their babies at night; many mothers find disturbed nights stressful and a difficult adjustment. Unfortunately a large number of mothers and their husbands have not been in contact with new babies and their demands, and therefore know very little about them apart from the unreal expectations presented in the media. Television programmes seldom

portray a constantly crying baby, and it's exhausted mother, and even the advertisements for breast milk substitutes, or disposable napkins, invariably show a smiling contented baby and a calm beautifully groomed mother. This last point was illustrated by the comments of a mother in the present study:

> "our routines have had to be adjusted to cater for children. Our baby disrupted our lives completely and it took us about six months to learn and adjust to thinking about a baby".

Young mothers often fail to understand that babies who wake and cry at night are quite normal; instead the mothers feel that they have inadequate mothering qualities if their babies do not sleep all through the night. This lack of knowledge adds to the mothers' stress and anxiety. The problem is compounded in houses where crying babies can disturb other members of the family, or can be heard by the neighbours; this happens particularly in flats and modern terraced and semi-detached houses, which is often the only accommodation that young families can afford.

Miles (1982) discussed Parsons' belief that there is a general value commitment in Western societies about man's mastery of the environment, with the notion that man is able to conquer his environment instead of having to adjust to it (very relevant to the early weeks of motherhood and attempting to conquer sleepless nights and crying babies, rather than adjusting as described earlier). Empirical research on illness behaviour has shown this orientation to be especially marked in the middle classes who are therefore particularly prone to the view that serious illness and other crisis situations are somehow due to negligence or wrong actions. In the present study, although not statistically significant, there was a noticeably higher proportion of depressed mothers in Social Class 2 and 3N, as shown in Chapter 6.

Another adjustment parents have to make shortly after childbirth is having additional adults in the home. In Britain, when new mothers live some distance away from their extended families, it is customary for their mothers, or mothers-in-law, or other family members, or even friends to visit and stay for a few days post-childbirth, to help the new mothers; this is encouraged by the midwifery service. Although these visitors may provide valuable assistance for the mothers, it also means other adjustments; especially when the mothers had not previously lived with their mothers-in-law, or their husbands with theirs. The modern homes mentioned earlier seldom have enough space to easily absorb other adults; perhaps this was easier for those families whose extended families lived nearby and provided adequate assistance without requiring board and lodging. Unfortunately nowadays, even when the families do live in close proximity many members of the extended family are working; therefore, there may be no person able to provide assistance during the day, and the working extended family may also be of little help at nights and weekends as they need their own rest at this time. The problems of adequate help for mothers are compounded in the following months and will be referred to again.

When the mothers' working husbands, or other family, take leave to help the mothers (husbands and extended family have no maternity leave), it may all be used by caring for other children while the mothers are actually having their babies. Once the husbands and extended families return to work the mothers are naturally reluctant to make further demands on them. However the midwives, general practitioners and health visitors, members of the Primary Health Care Team have at least minumum contact with mothers, in the first 6-8 weeks after delivery.

The midwives are responsible for providing maternity care daily

until at least 10 days postpartum, many general practitioners visit their patients in the first few weeks after childbirth and/or meet them at the postnatal clinic (6 weeks postpartum) and every mother is visited by a health visitor at least once shortly after the midwives complete their maternity care. Even with this involvement the health carers did not screen all the mothers suffering from the disorder, during these few weeks, in the present study. All this contact does not necessarily continue after the postnatal appointment; certainly the midwives' contact ceases, and the family practitioners normally only see the mothers when they or one of their children are unwell. The health visitors' contact varies and may be determined by the size and demands of their own caseloads. Therefore if the mothers depression began after six weeks they might not have met any members of the Primary Health Care Teams who could have recognised the problem and initiated the appropriate care.

There seem to be few persons in modern communities available (at any time in the postnatal year) to relieve mothers from their responsibilities, for a few hours, so that they can get some rest and sleep. This makes caring for depressed mothers very difficult. Even if the members of the Primary health care teams do recognise postnatal depression, anxiety, stress or tiredness, they cannot provide the type of care, that used to be available from mothers' families and communities.

It has been suggested that families living in a close-knit community of kin group and friends would receive more support than families in loose-knit networks. Many young families of childbearing age move away from their original homes to find and take up employment. If a young couple wanted to live with their parents accommodation would

be limited in an urban home. It may be difficult to find accommodation near their old family homes, and it may take time to get to know people and supportive neighbours in a new community. This is particularly important if both parents have been working (many mothers carry on working for 30, or more, weeks of their pregnancy).

Under these circumstances it was not surprising to find that 58% percent of the mothers who became depressed did so within the first six to eight weeks of having to care for their new baby. However 23% became depressed in the following four months and another 19% became so in the second six months of the year, as discussed in Chapter 6. The care for all these mothers would have been affected by the few people in the community who were available to help them. The mothers who became depressed in the last six months of the year would also have had less care from the health visitors during this period, because the health visiting involvement with families decreases markedly once the babies are weaned, and have grown past the six month developmental milestones.

Duration of the depression

Many mothers had a Postnatal depression that lasted for a few weeks only; this is similar to the periods of reaction found in other life crises (Caplan, 1974). Although this may be so, the mothers have to continue caring for their demanding babies during the crises. The effects of a postnatal reaction period on the mothers, and on their babies, and on their other relationships may have far reaching consequences.

The length of the depressive period has connections with the discussion above about the availability of help for mothers. If it is

difficult to find help for mothers in the first few postnatal weeks, it is even more difficult to find help for those mothers who become tired and depressed later in the year.

These consequences are possibly more serious for those mothers depressed for longer periods of time, even if the depression was not very intense. This is because a constantly tired and irritable mother, whether diagnosed intensely depressed, or not, is likely to experience inter-relationship difficulties.

The effects of postnatal depression on the marital relationship have been noted frequently by researchers and marital therapists (Dominian, 1974 and Edmonds, 1977). In Chapter 6, it was noted that a significant number of mothers believed their husbands had changed in a negative way in the year postpartum. This might be because the husbands had been changing anyway or they might have changed because their wives as mothers, felt constantly anxious, tired and irritable. On the other hand these changes might have been entirely in the mothers' perceptions, which of course could have been affected by their depressed feelings. The mothers and their partners may not understand these changed feelings, at this time, which could lead to failures of communication in their relationships. It is possible that extensive education for both parents, in antenatal classes and parent support groups, might assist them to be more tolerant of each other.

Recovery time

The actual time when the depression ended varied, and seemed to have little constancy. Mothers said they suddenly realised they felt different, or the depression just disappeared. One mother said her depression lifted when her baby had whooping cough, she said that she

was so worried and so busy with her sick baby, that she could not think about her own depression. Her relief when the baby's health improved was increased by realising her depression had lifted.

Although the present study only continued for 15 months after childbirth Dalton (1971) and Dominian (1974) provided evidence suggesting that some mothers remained postnatally depressed for years. Perhaps at least the seven (3%) out of 235 mothers who said that they had been depressed for over a year, may have remained depressed for some time. Health visitors only recognised three of the seven mothers who said that they had been depressed all year (described in Chapter 8). Surely the health care professionals especially the health visitors could be trained to recognise and help these women?

The other group of particular interest were the 15 mothers complaining of depression for a few days at a time throughout the year. Maybe these mothers had a cyclical depression associated with the menstrual cycle, and many mothers thought this was so, as discussed in Chapter 7. Interestingly health visitors thought that only two of these women had had postnatal depression.

These results raise the question "Why did health visitors not know about these depressed women?" Was it because the depression was not very serious, or because the mothers did not tell the health visitors, thinking that they would not be interested, or able to help them? Or did the health visitors simply not look for these problems?

Symptoms

All the mothers defined as depressed in the present study described symptoms of depression or excessive anxiety. The next most frequently reported symptoms were tiredness by 74%, irritability by 70% and tears

by 67% of mothers. These and other symptoms were all discussed in Chapter 6.

Perhaps health visitors estimated a low incidence of postnatal depression because they failed to recognise that these symptoms were part of the postnatal depression syndrome, although the symptoms have been well documented in other studies (Pitt, 1968; Kumar,1982 and Snaith, 1982). The above symptoms are different from those found in other depressive illnesses, such as suicidal ideas, worsening of the depression in the morning and early wakening. Postnatally depressed mothers seldom complain of suicidal feelings and their sleep difficulties are usually associated with getting to sleep at night, despite excessive tiredness. These points were confirmed by the mothers in the present study.

The depressed mothers' symptoms of anxiety, tiredness and irritability would probably have been found in response to other stress situations. Unfortunately though, the small dependent baby demands attention, without respite, whereas in many other stressful situations the stress may be avoidable for periods of time. These constant baby demands reduce the mothers' abilities to cope with the situation. Perhaps that is why the reaction continues for weeks or longer for many mothers.

The continual stress accompanied by a unrelenting tiredness leads to tears, and the emergence of unusual feelings which mothers find very distressing. In the present study the mothers reported an average of five symptoms each. In Chapter 6 the author noted that more symptoms would have been identified had there been a more personal system of information collection.

Tiredness is crucial. Who in the community can help mothers, or

look after their new babies while the mothers rest and recover from their tiredness? If the mothers have friends who are at home, and not working, it is likely that they also have small children, or other commitments, and cannot provide this help. It is unlikely that the health care workers, particularly the health visitor can provide the practical help required. Also, the voluntary organisations whilst providing a supportive service, seldom have personnel available to care for babies while mothers rest, and even if this is offered very tired mothers may think a time away from their babies is a good opportunity to catch up on their household chores. The only places beginning to offer help for tired mothers are paediatric and psychiatric wards in hospitals; they are starting to provide facilities for admitting excessively tired mothers and their babies. The mothers can rest while their babies are cared for by suitably trained staff.

Perhaps community and voluntary organisations should be making serious efforts to solve this problem by organising baby minding facilities, or home helps, for mothers who are tired. At present this is difficult, and anxious mothers are often reluctant to allow these organisations to care for their babies.

The points about family and community support and help for tired mothers were particularly relevant in the present study which took place in an area with a large mobile naval population. Most of these families lived on large naval housing estates, and in an easily identifiable community, with considerable resources provided by the Navy, such as Naval Family Services. The latter is an organisation providing a service similar to the social services. All this enhanced the potential community support of its members and was capable of even more. This last point was evidenced during the Falklands War (1982), when much

publicity was given to the excellent community support systems that developed in these naval communities during a time of crisis. However there were many other young families in the present study apart from naval who neither lived near their families nor in easily identifiable communities, for these families it might have been even more difficult to find help from neighbours and others.

The second postnatal depression symptom that requires more understanding is irritability. The mothers feel ashamed and upset with themselves when they find they are bad tempered and cross, with other members of the family, and they are particularly distressed if they find themselves being irritable with their babies. Health visitors and family practitioners understanding this symptom of irritability could help these mothers. If the mothers find the health carers understand their irritable feelings, they may find them more acceptable themselves, and less frightening. At the same time an explanation that tears are common may help mothers to be less distressed about their occurrence, and their husbands' understanding of the prevalence of tears at this time. The findings in Chapter 7 showed that a number of mothers described aggressive feelings towards their children. Interestingly health visitors did not report any knowledge of mothers' aggressive feelings in their observations of those mothers they had thought were depressed (described in Chapter 8).

Many postnatally depressed mothers had sleeping or weight difficulties, and a few mentioned a disinterest in sex. The sleep difficulties were generally characterised by exhausted mothers who could not get to sleep at night. These last three symptoms are also very important, although the health carers may possibly have to question the mothers before the symptoms become apparent.

Reasons for Postnatal Depression

At the present time there is only speculation about the aetiological factors of postnatal depression; despite the increasing amounts of research, to date little information is certain. Precursors of postnatal depression that have been suggested by previous researchers include the mothers' age, parity, social class, the birth process etcetera. In this study most of these were statistically insignificant. Nevertheless knowing possible precursors may assist the mothers and their health carers to take preventive action at the earliest opportunity.

Therefore the associations that were identified in the present study were particularly interesting and probably helpful. As mentioned earlier a significant relationship was found between postnatally depressed women and their feelings that their husbands had changed in a negative way, It was not clear whether the husbands, or the mothers, or both had changed. It was also noted that there was a relationship between the postnatally depressed mothers and their attitudes to their own upbringing; a statistically significant number of depressed mothers complained that they had been overmothered, which had probably denied them of learning how to manage in difficult and stressful situations.

It is unclear whether sick babies, or those with feeding problems, were precursors, associations, or consequences of postnatal depression. However the connection is important. Health visitors are very concerned about infant feeding and sick babies, yet the findings in Chapter 8 were not able to clarify whether the health visitors had made the connection between the baby who was sick or had a feeding problem and maternal depression. Five depressed mothers (who were not thought depressed by the health visitors) received extra health visiting care because of sick

babies or difficult feeders. It appears that health visitors should always anticipate this connection and care for both mothers and babies.

Certain mothers believed their depression began because they could not breast feed, or because they were breast feeding, or when they stopped breast feeding. Only some mothers commented on this aspect, so that systematic analysis was not possible, but some illustrative examples are quoted below:

"I worried because of difficulties with breast feeding...."

another said -

"I was depressed at a time that I had just stopped breast feeding and my periods had started again...."

a third mother said -

"I got depressed shortly after my mother had to go backtoher own home about three weeks after my baby was born. I had advice from the health visitor to change the baby from breast to bottle feeding and then I coped more easily..."

Perhaps these depressions were influenced by the mothers' hormone levels as noted by Dalton (1971), and as suggested by psychiatrists and biochemists (Nott, Franklin et al. 1976), who measured the connection between hormones and mothers' moods. However Gelder (1981) thought that research in this area was at an embryonic stage with no clear results. It was also possible that these depressions were associated with the mothers' self concept and self esteem, as suggested by Beattie (1978).

Although combined biological and sociological research would enhance the current knowledge about postnatal depression, the present study was particularly concerned with the sociological associations of Postnatal Depression. These may be related to changes in modern society, not only the changing structure of families and the community's support systems, but also to other fundamental differences in motherhood.

Nowadays we educate and prepare women for work, and achievements outside their homes, when they leave school. This may be appropriate for a modern technological world, but it means women leave school and enter the world of work, having little time for home-making, and gaining little knowledge about motherhood. Frequently women stay at home, for the first time, after they have had their first babies.

It may take time for mothers to adjust to their new motherhood and homemaking status; they may think it inferior to others in the working world. Their working extended family cannot support them (as mentioned earlier), and neither can their recent working colleagues. They have to find new friends. This can in itself be a difficult undertaking as they may meet few people while coping with the demands of their new babies. It appears, from information described in Chapter 6, that many young mothers have no close confiding relationships; many women described having coffee with friends as a community group involvement, but many others mentioned no contact with community groups at all; amazingly, very few mothers mentioned neighbours, or friends, as confidantes to whom they would turn for sharing their personal problems.

9.7. OBJECTIVE C. WHETHER HEALTH VISITORS COULD IDENTIFY MOTHERS WHO WERE "AT RISK" OF DEVELOPING POSTNATAL DEPRESSION, AND WHETHER THEY COULD RECOGNISE ALL THOSE MOTHERS WHO SUFFERED FROM THIS PROBLEM IN THE YEAR FOLLOWING THEIR CONFINEMENTS?

Health visitors only thought 14 (16%) out of 235 mothers were "at risk" and most of these indeed did become depressed. If these mothers had not become depressed it might have meant that the health visitors

had instituted appropriate preventive care. These results suggested that health visitors were not recognising vulnerable persons in their immediate working environment. Also when they had anticipated the development of postnatal depression any care offered had been insufficient to prevent its occurrence.

Surprisingly the health visitors also only recognised a small proportion of the depressed mothers, 27 (25%) out of 110 mothers. Possibly one reason for this disappointing result was that although certain researchers use Pitt's definition of postnatal depression, most researchers have based their studies on their own subjective definitions, which are seldom in accordance with each other, and which they have not recorded clearly in the literature. Therefore health visitors, together with others, have not gained a clear understanding of postnatal depression from these studies and do not know what to lookfor.

Thus it was unlikely that health visitors had a clear conceptual image of postnatal depression that fitted Pitt's 4 Criteria (which was used by the author in this study). This definition was explained to the health visitors by the author during the preparatory meetings which took place before the information was collected. The definition was deliberately not repeated, at other times, because the study aimed to establish by survey methods whether health visitors' training and education, and their professional experience and opportunities, had prepared them to recognise mothers "at risk" of, and/or suffering from postnatal depression. The study was not an experiment, which it would have been had the health visitors been given the definition, and then asked to find the mothers who met these criteria. Nonetheless in the Health Visitor Recording Schedule 1 Part C - Regular (Appendix D) there were many questions which could have prompted the health visitors

to have been more aware of, and more concerned about the mothers' feelings.

The health visitor recording schedules were also designed to collect information about any concerns that the health visitors may have had about the mothers whether depressed or not. The findings, in Chapter 8, showed that health visitors had had no concerns at all about 67 (61%) of the 110 mothers who were identified as postnatally depressed.

It should be emphasised that the author defined the 110 mothers postnatally depressed from subjective information the mothers gave her when she enquired about their feelings. This information could also have been available to the health visitors, who had far more contact with the mothers, than the author had, during the postnatal year. The maximum contact the author had was two home visits with less than 60 of the mothers, in contrast there were an average of 13 contacts between the health visitors and the mothers in their care, as described in Chapter 8. Yet for some reason the health visitors did not gather the information. In this study, it was found that the longer the postnatal depression lasted the more likely the health visitor would be to recognise the problem.

9.8. OBJECTIVE D. WHAT SKILLS HEALTH VISITORS USED TO SCREEN AND IDENTIFY POSTNATALLY DEPRESSED WOMEN.

Four skills will be discussed: contact making in homes and clinics, searching for health needs, recognising the symptoms and teamwork.

Contact in Clinics and Homes

The first skill concerned the opportunities health visitors created for meeting mothers, obviously a pre-requisite for providing care.

Two interesting contact patterns emerged in the present study. Firstly, a statistically significant proportion of the postnatally depressed mothers received considerably more home visits from health visitors than the non-depressed mothers did; in Chapter 8 it was shown that 20% of the depressed mothers had 11, or more, home visits compared with 2% of the non depressed mothers.

Warner (1983) found that health visitors did not allow mothers to talk about themselves in clinics. Results in the present study may have been consistent with this, as no differences were noted in the number of clinic contacts for the depressed, or non-depressed mothers. This could have meant that in clinics the mothers received the same care whether they were depressed, or not. The mothers choose whether they attend clinics, whereas health visitors decide whether they do home visits; this suggests that the depressed mothers were not choosing to use clinics, for their own care, any more than the non depresed mothers were.

There is no research evidence proving that health visiting care given in home visits is superior to that given in clinics. Nevertheless the author assumed that there may have been more time available during home visits for talking with mothers. This is especially so as few clinics have an appointment system; the author knows the difficulties of spending time with mothers in 'drop in' clinics, when there are many other mothers waiting for attention (Hennessy, Moulds and Crack, 1983).

The different contact between health visitors and depressed mothers in home visits, and clinics, possibly supported Orr's (1980) findings that

clients perceive clinics and home visits as two distinct points of the health visiting service.

These meetings between health visitors and mothers are part of health visiting care and can be conceptualised from the viewpoint of the social-influence process (Egan, 1975); when health visitors involve themselves with their clients they become the one who influences, or educates, and one who is influenced or gathers information, it is a continuous two-way process which can be used constructively and creatively in health care. It is difficult for the author to understand how health visitors could be part of this process with mothers, and not learn how the mothers were feeling at the time, or about past periods of depression. It is even more extraordinary because, in the present study, the health visitors met the mothers an average of 13 times each, which was more than the recommended contact frequency in the health district at the time. For example one mother who had had more than average contact with her health visitor, wrote to the author begging for help. She described her own bizarre behaviour (which included violent aggression towards her husband and children) that had developed since the birth of her baby; yet this mother had not been recognised as depressed by her health visitor.

The author suggests that, as with Warner's findings about clinics, many health visitors do not allow mothers to talk about their feelings in their homes either. Associated with this point are two other skills noted in this study, symptom recognition and the method of searching for health problems.

Symptom Recognition

There are certain postnatal depression symptoms which health

visitors may not have realised could be symptoms of postnatal depression especially tiredness, anxiety and irritability, as discussed earlier in this chapter. This highlights an area of health visiting education that needs attention. On the other hand, perhaps health visitors could themselves be more enquiring about information that is necessary for meeting the requirements of their clients.

The author assumed that the health visitors had not recognised depressive symptoms in many mothers because they only identified 27 (25%) of the 110 postnatally depressed mothers, whereas all these mothers told the author that they had been depressed for a minimum of 2 weeks and in many cases much longer and they described at least 4 depressive symptoms each. Possibly health visitors not only avoided labelling the mothers postnatally depressed, but have learnt from experience that the depression lifts whether they recognise it, or not. On the other hand they may have thought it was not the health visitor's work but rather the family practitioner's to recognise postnatal depression.

Searching

The technique of searching was observed during the fieldwork and was described in Chapter 8. It was noted in one third of the 6 month visits that there was no search for maternal problems. This was the case even in a highly biased sample of health visitors who had indicated some knowledge about postnatal depression.

In these visits it was observed that certain mothers required direct but sensitive questioning before exposing their feelings, and others offered the health visitors cues that were not taken up. One wonders if this explains why many mothers who were defined as depressed

in the study, were not thought to be so by the health visitors.

Some postnatal depression symptoms can be detected by observation, others require deliberate searching, with routine and careful enquiry. Luker (1982) challenged health visitors' belief that it was important to build up a relationship before focussing health visiting intervention and asking the personal questions which are necessary to establish the client's health needs. She argued that a relationship already exists between a health visitor and her client in a form of pre-determined role expectations. She also contended that using the direct approach from the beginning may be less confusing to the clients, who expect the relationship to be direct and based on the health visitors' professional knowledge, rather than on a social footing.

Building on Luker's discussion, it appears that health visitors can choose one of two ways of searching for emotional health problems. Health visitors can either ask direct questions in a structured clinical way and expect direct answers or they can use a relationship-type approach using the social interaction (described above in the section on Contact in Clinics and Homes) to elicit even more meaningful answers, so that postnatally depressed mothers are detected.

For example a health visitor can say to a mother directly "are you anxious?" and elicit an answer "yes" or "no" or she could put the question "how are you feeling .....?" giving the mother time to think, and understand, and describe how she is feeling in words, especially if the mother had been repressing these feelings. The latter method is called client-centred and not only uses the skill of searching but it can also be therapeutic for the mothers (Rogers, 1971).

In the present study it was noted that certain health visitors did not search for maternal health needs at the six months visit. However a

large portion of health visiting time was spent on searching for signs of potential health problems in the children, and the author questions why similar attention was not paid to mothers. It was not obvious from the findings described in Chapter 8 thathealth visitors are wasting the chance to consider maternal needs in the routine home visits. When the maternal needs were not considered one wonders whether the home visits had any advantages over time spent with families in clinics. If health visitors do not routinely search for maternal needs, or identify them, these health visitors might just as well withdraw from routine home visits as children get older. This is because much of the health visiting care provided for children, as they get older, could well be done in clinics with the better facilities they can provide. Although the author would prefer health visitors to improve the care they provide in home visits for children and to include mothers.

The value of the home visits will definitely improve if the visits are structured, and the health visitors routinely attempt to establish the health needs of both the mothers and their children at every contact. This is the very minimum required when working according to the Nursing Process (Kratz, 1979) which is being adopted by many health visitors (Rogers, 1982 and Clark, 1982).

One reason for not searching for maternal health needs may have been that this would have been time-consuming, as would have been the necessary care if needs were identified. An earlier discussion disclosed the possibility of inadequate available care for these mothers from their families, and communities. Health visitors may know intuitively, and from experience, that they cannot supplement this. Perhaps it is unethical to unearth problems if appropriate care cannot be provided.

The time required for certain types of health visiting work was also raised by Luker (1982), by noting, as did Dingwall (1977), that health visitor students did not like visiting elderly people, because the visits took too long. Luker's experimental study suggested that visits to the elderly do not need to take longer than visits to other age categories, but rather that health visitors may experience some difficulty in terminating the visit. Similarly it is possible that health visitors avoid looking for postnatal depression during home visits because the visit will be extended and difficult to terminate.

Certainly terminating interviews in relationship-centred work such as counselling is a skill (Noonan, 1983 and Gough, 1984) which health visitors may not have been taught or learnt. Noonan discussed terminating interviews when counselling adolescents and Gough described terminating interviews in a private counselling practice.

Terminating interviews between health visitors and postnatally depressed women is more complex than those described in the above references because of the nature of health visiting. In the references the clients had approached the counsellors for help, whereas health visitors initiate the home visits. Similarly in the referenced examples the counsellors and the clients probably discussed the time available for the session/s at the beginning of their relationships, and it would have been understood that the sessions would normally be terminated when the clients' difficulties had been resolved. The emphasis is different in health visitors' home visits, as the relationship between the health visitors and postnatal mothers normally continues until the mothers' last child is at least five years old, during which time health visitors will be in frequent contact with the mothers so as to survey their

children's development. Therefore health visitors work hard to maintain satisfactory professional relationships, and they would be anxious for the home visits to be long enough, but not too long. Similarly they might want to avoid situations which might disturb these relationships; for example there is no clear cut point when the depression is over, as there would be in other health problems, or life crises, this makes terminating a session/s difficult and it would be easier for health visitors if they do not find the depression in the first place.

There may have been other issues preventing health visitors from searching for postnatal depression, for.example, possibly the health visitors were avoiding one-to-one adult relationships which would permit the mother to pour out her feelings of unhappiness and pain - where the health visitor can only listen, feeling that there is no advice to be given, or action to be taken. This is perhaps unnecessarily pessimistic not to say a defeatist view. 'Just listening' can itself be therapeutic, while some authorities such as Marian Strehlow (formerly professional adviser to the Council for Education and Training of Health Visitors) have argued boldly that health visitors should enter the area of counselling. In 1978 she published a seminal article entitled 'Is the Health Visitor a Counsellor?' in which she said:

> "it would seem that health visitors cannot be anything but a counsellor in many situations, ... and the aspect of counselling is achieved in the first instance by being a good listener, by hearing not only what people are saying, but also what they mean to say ....." (Strehlow, 1978).

Such a development however would have its price. If health visitors were to do this day after day, they themselves would require a time and place to offload the pressures of this accumulated pain and anxiety. Menzies (1970) observed a tendency for nurses in hospitals to erect defences against psychological pressures, perhaps health visitors do the

same and avoid emotional areas that will cause stress.

In Chapter 3 the author raised the issue of support and counselling facilities for health visitors. Health visitors cannot be expected to constantly work in painful emotional areas without some support. A few facilities have developed (Spicer, 1978 and 1980, Goodwin, 1980 and others). The last mentioned included a group in Gosport which the author initiated and to which she belonged; the group met for an hour, fortnightly, for more than three years. The value of this group was indicated by the members' regular attendance during this period. However it is definitely not a part of the structure of every health visiting service to provide time and opportunities for regular personal counselling and support groups.

Support groups are very important to avoid a phenomenon termed professional 'burnout'. This term is used to describe a condition of severe exhaustion found primarily among people who work in helping professions. The syndrome is characterised by physical and emotional fatigue, disillusionment and depression (Edelwich and Brodsky, 1980). Burnout rates may be lower for those professionals who actively express, analyse and share their personal feelings with their colleagues. Not only do they consciously get things off their chest, but they have an opportunity to receive constructive feedback from other people and to develop new understandings of their relationship with their patients or clients. In Chapter 2 the difficulty that people have in getting any feedback about their actions from present society was described; this applies to professionals and health visitors too. Following on the last point perhaps health visitors find it easier and less complicated if they only allow mothers to talk about their children's health problems. Similarly it is probably easier to survey the health of children rather

than that of mothers. The author believes that in a society where public health services have led to high standards of living and good physical health for the whole population including children the high proportion of emotional health problems in adults needs attention. Postnatal depression is far more common than any childhood illness or developmental delay.

Teamwork

The fourth skill used by health visitors for screening and identifying postnatal depression could be called team work, or liaising with other members of the primary health care team. Facts in the present study suggested that health visitors could use more information that was available from other primary health care team members, however these findings were not statistically significant.

For example the health visitors could have benefited from liaising with the midwives and gathering their impressions about the mothers' emotional health during their antenatal and early postnatal contact, particularly as the midwives appeared to have correctly identified more mothers "at risk" of postnatal depression than the health visitors did. Recent research evidence (Kumar, 1982) suggests that the mothers' emotional health in pregnancy may be indicative of her health postnatally.

Similarly the family practitioners and health visitors were not in total agreement about which mothers were depressed; if there were more liaison between these team members about the emotional health of their patients or mothers it is possible that health visitors would find their role in the mothers' health care clearer. Perhaps this does not happen because the family practitioners' are also unclear about what health

visitors could do, and perhaps they perceive that health visiting is working with children just as many health visitors apparently see themselves.

9.9. OBJECTIVE E. WHAT PREVENTIVE METHODS HEALTH VISITORS USED FOR THOSE MOTHERS "AT RISK".

Unfortunately it was very difficult to achieve this objective as health visitors thought few mothers were "at risk" and most of these did become depressed which suggests any extra health visiting care was unsuccessful. Also the health visitors expressed little health visiting concern about any mothers apart from those they had recognised as postnatally depressed. Therefore the analysis of the preventive methods (objective e) was not feasible.

9.10. OBJECTIVE F: WHAT SKILLS HEALTH VISITORS USED TO MEET THE NEEDS OF THE WOMEN WHO HAD POSTNATAL DEPRESSION.

Disappointingly, similar to those mothers "at risk" above, it was also difficult to establish what skills health visitors used to care for the mothers who actually suffered with postnatal depression because the health visitors had recorded very little about this care. Nevertheless certain skills became apparent, especially in the observed visits, such as allowing mothers to talk about themselves and then listening to them as they did so. This appears to be fundamental in the care of postnatal women, and had the two-fold purpose in health visiting of enabling the search for health problems discussed earlier in the Chapter and

providing therapeutic opportunities.

The other caring skills that were observed by the author, or recorded by the health visitors, were discussed in Chapter 8 and in other sections in this Chapter; these included more home visits for a proportion of the depressed group of mothers and sharing their care with other professionals.

In the present study the mothers were not asked whether they wanted the health visitors to help them, but mothers mentioned health visitors as people they would contact for help for themselves.

In the mothers' questionnaires mothers were given the opportunity in unstructured questions to say whatever they wanted to; many spontaneously asked for help to understand their feelings.

It would seem that health visitors should be involved in this explanation, because health visitors meet all mothers of small children, and postnatal depression appears to be a problem of epidemic proportions, far more common than any childhood illness or child developmental delay. The public are asking for health visitors' involvement as well, and psychiatrists are suggesting health visitors could do much of this work.

Once a professional has recognised postnatal depression the next step is reassurance, which needs time for listening to the mothers and sharing their feelings. This requires a counselling approach, however there is also an educational element (refer to definition of Counselling in Glossary) especially as the health carers may have to explain the pattern of postnatal depression to the mothers and their families.

Following reassurance and clarification the care of postnatally depressed mothers includes the support of the mothers and families over a period of time. The professional carers may of necessity try to share

this support with other members of the family, particularly the maternal grandmothers where appropriate, and community groups. Although there are numerous different community support groups, they too become overburdened by the large numbers of depressed mothers and find it increasingly difficult to maintain the care the mothers need. In the present study it was shown that the health visitors were not always aware of the community groups the mothers used, and it is doubtful whether other health carers are better informed.

The family practitioners are of course also in close contact with these mothers and will prescribe medication if and when necessary. However surely health visitors and general practitioners should work together, with health visitors doing most of the listening to mothers as they are normally in regular contact, and can certainly offer the mother more than 6 minutes (the average time of an appointment in a family practitioner surgery). Also health visitors have knowledge about the mothers' families and community resources and should therefore be able to motivate for the provision of appropriate support. Similarly the mothers' health visitors and family practitioners should liaise together to predetermine which mothers the health visitors will refer to the family practitioner for medication, or further referral for psychiatric care. The author suggests those mothers who fit the Pitt's 4 Criteria for postnatal depression and have a particularly disabling symptom such as being unable to get to sleep at night should be referred to the general practitioners.

9.11. OBJECTIVE F: WHETHER OR WHERE THE HEALTH VISITING SERVICE SHOULD BE IMPROVED IN THIS AREA

This objective will be discussed in the recommendations:

RECOMMENDATIONS

1. Health visitors need guidance about moving a proportion of their attention from children to adults.

2. Health visitors need guidance and clarification about their entitlement to work in emotional health. For example they require guidance about their ability to identify emotional health problems.

3. They need more knowledge about postnatal depression. They need to know what it is, the incidence, the symptoms and its course.

4. They need reassurance that they can identify the syndrome and institute appropriate non-medical care.

5. They need to know how to observe, search for, and recognise the symptoms.

6. Health visitors need to be taught how to ask people personal questions without increasing anxiety, and how to listen to the answers. They need to allow people/ clients not to answer if they do not want to, but to make provision for their clients to do so at a later date, should they wish to.

7. Many health visitors already have the counselling and communication skills described in 5 and 6, but they and all other health visitors require personal encouragement and guidance to continue working with adults´ emotions day after day. For this to happen the health visiting service should enable regular structured well-led peer group support, or group counselling. Additionally there should be adequate guidance about counselling from suitably experienced people.

8. Health visitors need guidance about the care they can give and arrange for mothers, especially, when mothers need referral for specialist care from the family practitioners or social workers. Every health visitor needs to think about this point, and make decisions determined by their own abilities, the abilities and availability of other members of the primary health care team, and the availability of community resources. These decisions should be made before the search for postnatal depression begins.

9. It is suggested that health visitors provide mothers with opportunities to talk about their own feelings whenever appropriate.

10. Health visitors should always note the connection between babies with feeding problems and depressed mothers and provide care for both.

11. Routine health visiting should be planned to meet the needs of mothers as well as monitoring children´s developmental milestones.

12. Once health visitors have identified postnatal depression they need

to reassure the mothers and their families. One way of doing this is for health visitors to share their knowledge with the mothers; this will include the possible course of the disorder, and the care and support the mothers will need.

13. It is suggested that health visitors can provide immediate help when the disorder is first identified. Thereafter the health visitors should encourage the mothers' families and communities to provide most of the long term care, and support, needed by the mothers; this of course should not exclude specialist help or medication when necessary.

14. Health visitors should promote self-help support groups for mothers in the community. When these groups exist health visitors can provide valuable professional encouragement to the organisers.

15. Research is needed about health visitors' relationships with self-help groups.

16. Health visitors in their role in the promotion of health care are in the front line to educate prospective parents about the realities of motherhood especially the adjustment and tiredness factors and the need to establish family and community support systems.

17. All this work, individual and group work, should be recorded.

18. It would be invaluable if managers would routinely, rather than only in crises, provide health visitors with opportunities for case discussion. This would enhance health visiting, as health visitors

normally work in isolation with little feedback, and aspects are largely unseen and cannot be evaluated, for example their effectiveness in health promotion.

19. Most of these recommendations are transferable and appropriate for the health visiting care of other emotional problems, such as the care of families with a bereavement.

20. Health visitors must attempt to relate their health visiting care to the health needs of the population they care for; frequently this population is a few hundred families and especially mothers and their pre-school children.

GLOSSARY

Antenatal clinics - clinics for the health care of pregnant women.

Blues - a transitory emotional reaction, usually tears, experienced by many mothers, shortly after childbirth and lasting for hours or a few days.

Birth visit or Primary Visit - the first visit of the health visitor to the mother after the midwife has completed her care.

Chi-square tests can be used to determine whether an observed frequency distribution departs significantly from a hypothesized frequency distribution.

Contact times - the times the health visitor meets the mother, at home, in the clinics, surgeries and elsewhere.

Crisis intervention - caring in an effective way for those in emotional distress or crisis._

Counselling - that activity in which through interaction between two persons (i.e. the counsellor and another) - the other may be helped to reach sel-determination and self discovery. This can also be termed an educational process that affects both participants (Royal College of Nursing, 1983).

Dysmenorrhoea - painful menstruation.

Expected date of confinement - 40 weeks after conception.

Epidemiology - the scientific study of factors that influence the frequency and distribution of disease in man.

Gaussian distribution - a statistical term measuring the normal distribution in the population.

Mothercraft class - class to teach mothers about childbirth and child care.

Notification of births - a midwife must notify the District Community Physician of all births (The Notification of Births Act 1907).

Primary Health Care Team - a group of persons usually including a family practitioner, other paramedicals, eg a midwife and a health visitor and the patient. The team work together to provide patient care.

Z Score - indicates the placement of the score with respect to the mean of the distribution.

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APPENDIX A

CONFIDENTIAL

PITT'S ANXIETY TEST

QUESTIONNAIRE

No. ..... Date .....

Date of Birth/Expected Date of Birth .....

We are asking you these questions in order to find out how you feel about things during this time of having your baby. Your answers will help us to help you. We want your answers to tell us how you feel at the present time, that is today, or over the past few days.

Please read the questions carefully and then answer as frankly and honestly as you can. Just answer "Yes" or "No", putting a circle round your own answer. If you really cannot make up your mind, you may put a circle round "Don't Know", but try to avoid this if you can.

Don't spend too much time on any one question, but please don't miss any out. After you have finished the questions, you are invited to write a few of your own words about the way you feel, in the blank space at the end of this form.

AT THE PRESENT TIME -

1. Do you sleep well?	YES	NO	DON'T KNOW
2. Do you easily lose your temper?	YES	NO	DON'T KNOW
3. Are you worried about your looks?	YES	NO	DON'T KNOW
4. Have you a good appetite?	YES	NO	DON'T KNOW
5. Are you as happy as you ought to be?	YES	NO	DON'T KNOW
6. Do you easily forget things?	YES	NO	DON'T KNOW

AT THE PRESENT TIME -

7. Have you as much interest in sex as ever?	YES	NO	DON'T KNOW
8. Is everything a great effort?	YES	NO	DON'T KNOW
9. Do you feel ashamed for any reason?	YES	NO	DON'T KNOW
10. Can you relax easily?	YES	NO	DON'T KNOW
11. Can you feel the baby is really yours?	YES	NO	DON'T KNOW
12. Do you want someone with you all the time?	YES	NO	DON'T KNOW

AT THE PRESENT TIME -

13. Are you easily woken up?	YES	NO	DON'T KNOW
14. Do you feel calm most of the time?	YES	NO	DON'T KNOW
15. Do you feel that you are in good health?	YES	NO	DON'T KNOW
16. Does food interest you less than it did?	YES	NO	DON'T KNOW
17. Do you cry easily?	YES	NO	DON'T KNOW
18. Is you memory as good as it ever was?	YES	NO	DON'T KNOW

AT THE PRESENT TIME -

19. Have you less desire for sex than usual? YES NO DON'T KNOW
20. Have you enough energy? YES NO DON'T KNOW
21. Are you satisfied with the way you're coping with things? YES NO DON'T KNOW
22. Do you worry a lot about the baby? YES NO DON'T KNOW
23. Do you feel unlike your normal self? YES NO DON'T KNOW
24. Do you have confidence in yourself? YES NO DON'T KNOW

Is there anything you want to add about your feelings at the moment?

If so please write it here:

APPENDIX B

(Distributed with Health Visitor Recording Schedule 1)

NOTES TO HEALTH VISITORS

Thank you very much for participating in this study.

I will be grateful if you could place the completed questionnaire in the attached envelope and return it to me as soon as possible after the 6-week postnatal interview.

Please read the permission note on the front of the questionnaire to the mother.

In Part A, the midwives are prepared to answer question 10.

Part B - is straightforward.

In Part C - your professional opinion is required in addition to the mother's information.

Please telephone me at if you have any queries at all.

APPENDIX C

(Distributed with Health Visitor Recording Schedule 1)

NOTE TO MOTHERS

We are doing a project on postnatal women and I would be grateful if you would be willing to assist us. If you are agreeable your health visitor will ask you a few extra questions during her visits. Your answers will be confidential.

D HENNESSY

Investigator and Health Visitor

POSTNATAL RESEARCH APPENDIX D

HEALTH VISITOR RECORDING SCHEDULE 1

PART A

HEALTH VISITOR:	DATE OF:	LEGAL STATUS:
(or Relief Health		(Circle correct
Visitor's No.)	MOTHER'S BIRTH	Answer)
CASE NO. 1, 2, 3, 4	BABY'S BIRTH	SINGLE
BABY'S CODE NO:	ANY MISCARRIAGES:	DATE WHEN:
PLACE OF BIRTH	BIRTH DATES OF	MARRIED
	PREVIOUS LIVE	
	CHILDREN	WIDOWED
	BIRTH AND	DIVORCED
	DEATH DATES OF	
	DECEASED CHILDREN	SEPARATED
	DATE OF STILLBIRTHS	

WHERE APPROPRIATE

CIRCLE CORRECT ANSWER

1. Has the mother suffered with dysmenorrhoea in the last 3 years? YES/NO/DON'T KNOW

2. Husband/Cohabitee's Occupation: .....

For the cohabitating mother, is this a continuing relationship? YES/NO/DON'T KNOW

Have you any other relevant information regarding the above question? If so, give details on reverse.

3. Does this mother have a predominantly good relationship with her partner? YES/NO/DON'T KNOW

4. Mother's occupation prior to childbirth: .....

5. Type of accommodation: .....

6. Is ther any help available from the extended family? e.g. mother, mother-in-law - or any other.

7. How long have you known this mother?
Did you have any contact with her during pregnancy? YES/NO

8. Did the mother attend Mothercraft classes during this pregnancy? YES/NO

9. Does the midwife think this mother will develop

postnatal depression? YES/NO/DON´T KNOW

If you answered ´YES´, what reason was given by the midwife?

HEALTH VISITOR RECORDING SCHEDULE 1

PART B

AFTER PRIMARY BIRTH VISIT

Date of Visit: .....

Please answer all the questions as accurately as possible.

CIRCLE CORRECT ANSWER WHERE APPROPRIATE

1. Type of pregnancy: NORMAL/COMPLICATED

2. If a complicated pregnancy, please give details.

3. Type of delivery: NORMAL/FORCEPS/LSCS

4. a. Length of delivery: Stage I ..... hours)
)
Stage II ..... hours) Please
) complete
Stage III ..... hours)

b. Was husband/cohabitee present at delivery? YES/NO/DON'T KNOW

5. a. Has the puerperium been normal/complicated? YES/NO/DON'T KNOW

b. Please give details of any complications.

6. a. Have there been, or are there any problems with the baby? YES/NO/DON'T KNOW

b. Please give details of any problems.

7. Has breast feeding been attempted? YES/NO

8. Has breast feeding been established? YES/NO

9. Do you think this mother is likely to develop postnatal depression? YES/NO/DON'T KNOW

10. Please could you give the reason for reply to Question 9 and/or make any other relevant comments.

HEALTH VISITOR RECORDING SCHEDULE 1

PART C -REGULAR VERSION

CHOSEN TYPE OF CONTRACEPTION: .....

6-WEEKS POSTNATAL INTERVIEW: Date of Interview: .....

PLEASE READ THE QUESTIONS CAREFULLY AND ANSWER AS FRANKLY AND HONESTLY AS YOU CAN. JUST ANSWER "YES" OR "NO" PUTTING A CIRCLE AROUND YOUR ANSWER. IF YOU CANNOT MAKE UP YOUR MIND, YOU MAY PUT A CIRCLE AROUND "DON'T KNOW" BUT TRY TO AVOID THIS IF YOU CAN. PLEASE DO NOT LEAVE ANY QUESTIONS OUT. AFTER YOU HAVE FINISHED, PLEASE ADD ANY EXTRA COMMENTS YOU HAVE AT THE END OF THE QUESTIONNAIRE.

1. REPORTED PHYSICAL CHANGES

a. Has the mother's appetite decreased? YES/NO/DON'T KNOW

b. Is she attempting to lose weight? YES/NO/DON'T KNOW

c. Has she lost weight? YES/NO/DON'T KNOW

d. Is her weight loss more than would normally be expected after birth of baby? YES/NO/DON'T KNOW

(If known, please give the approximate

amount of weight loss.)

e. Is the mother constipated? YES/NO/DON'T KNOW

f. Is mother's speech obviously slower than expected? YES/NO/DON'T KNOW

2. REPORTED SLEEP CHANGES

a. Can she get to sleep at night? YES/NO/DON'T KNOW

b. At night, does she wake at times other than when the infant cries? YES/NO/DON'T KNOW

c. Does she wake early in the morning and find it difficult to go back to sleep? YES/NO/DON'T KNOW

d. Does she have any other sleep disturbances? YES/NO/DON'T KNOW
If "YES" please explain.

3. MOTHER'S REPORTED MOOD

a. Is the mother 'fed up'? YES/NO/DON'T KNOW

b. Is she unhappy with good reason,
i.e. trouble with baby, bereavement,

husband? YES/NO/DON'T KNOW

c. Is she unhapy without an obvious reason? YES/NO/DON'T KNOW

d. Does the mother have crying spells? YES/NO/DON'T KNOW

e. Does mother feel a great change in libido/sexual desire? YES/NO/DON'T KNOW

4. MOTHER'S REPORTED FEELINGS ABOUT HERSELF

a. Does the mother feel positive about herself? YES/NO/DON'T KNOW

b. Is her general attitude to life positive? YES/NO/DON'T KNOW

c. Does she criticise herself? YES/NO/DON'T KNOW

d. Can she make decisions? YES/NO/DON'T KNOW

e. Does mother feel her appearance is neglected? YES/NO/DON'T KNOW

NOTE: WHERE THE WORD 'HUSBAND' APPEARS, WHERE APPROPRIATE PLEASE READ 'SEXUAL PARTNER'

5. MOTHER'S REPORTED RELATIONSHIP WITH HER HUSBAND SINCE THE BIRTH

a. Has mother's emotional attachment to her

husband changed? YES/NO/DON'T KNOW

b. Is she less attached to husband than she was before the birth? YES/NO/DON'T KNOW

c. Is she more attached to husband than she was before the birth? YES/NO/DON'T KNOW

d. Does father assist the mother? YES/NO/DON'T KNOW

6. HEALTH VISITOR'S OBSERVATIONS AND MOTHER'S REPORTED RELATIONSHIP WITH HER BABY

a. Have the baby and mother been separated at all? e.g. mother into hospital without baby, or baby in hospital without mother? YES/NO

b. Are the baby and mother together now? YES/NO

c. Does the mother feel she is relating well with the baby? YES/NO/DON'T KNOW

Does your professional judgement support this answer? YES/NO/DON'T KNOW

d. Is the mother trying to respond to the demands of her baby? YES/NO/DON'T KNOW

Do your observations support this answer? YES/NO

e. Does the mother feel she can cope with her responsibilities? YES/NO/DON'T KNOW

f. Can the mother cope with her baby? YES/NO/DON'T KNOW

7. BABY SECTION

a. Has the baby had any problems? e.g. prematurity, low birth weight, congenital, etc. YES/NO/DON'T KNOW

b. Has the baby had any feeding problems? YES/NO/DON'T KNOW

c. Has the baby any illness, e.g. thrush, etc. YES/NO/DON'T KNOW

(If YES to a., b. and/or c. please give details.)

8. THE HEALTH VISITOR'S IMPRESSION ABOUT THE MOTHER'S INTERACTION WITH THE COMMUNITY

a. Is she meeting other people? YES/NO/DON'T KNOW

b. Is the mother avoiding other people, e.g. not going out? YES/NO/DON'T KNOW

c. Is the mother making excessive demands on husband? YES/NO/DON'T KNOW

d. Is mother making excessive demands on other members of the family? YES/NO/DON'T KNOW

e. Is mother making excessive demands on health visitor/or Primary Health Care Team? YES/NO/DON'T KNOW

9. HEALTH VISITOR'S OBSERVATIONS ON MOTHER'S APPEARANCE

a. Does the mother look anxious or unhappy. YES/NO/DON'T KNOW

b. Does the mother look at you when she talks to you? YES/NO/DON'T KNOW

c. Does mother's posture have a confident appearance? YES/NO/DON'T KNOW

d. Is mother's personal appearance and grooming neglected? YES/NO/DON'T KNOW

10. HEALTH VISITOR'S PROFESSIONAL OPINION

a. In your opinion, has this mother had postnatal depression during the past 6 weeks? YES/NO/DON'T KNOW

b. In your opinion, does this mother have postnatal depression now? YES/NO/DON'T KNOW

c. Has she been referred to GP/psychiatrist for this problem? YES/NO/DON'T KNOW

d. Is this mother taking any drugs at all? YES/NO/DON'T KNOW
State which drugs.

e. Do you think this mother may develop postnatal depression during the subsequent weeks? YES/NO/DON'T KNOW
Please elaborate on your answer.

WOULD YOU LIKE TO MAKE ANY OTHER COMMENTS OR EXPAND ON ANY OF THE ABOVE QUESTIONS?

IF SO, PLEASE USE THE SPACE BELOW:

HEALTH VISITOR RECORDING SCHEDULE 1

PART C - SHORTENED VERSION

HEALTH VISITOR NO.

(or relief Health Visitor's No.)

Case No. CHOSEN TYPE OF CONTRACEPTION

Baby's Code No. DATE OF INTERVIEW .....

6-WEEK POSTNATAL INTERVIEW

HEALTH VISITOR'S PROFESSIONAL OPINION:

a. In your opinion, has this mother had postnatal depression during the past 6 weeks? YES/NO/DON'T KNOW

b. In your opinion, does this mother have postnatal depression now? YES/NO/DON'T KNOW

c. Has she been referred to GP/psychiatrist for this problem? YES/NO/DON'T KNOW

d. Is this mother taking any drugs at all?

State which drugs? YES/NO/DON'T KNOW

e. Do you think this mother may develop postnatal depression during the subsequent weeks? YES/NO/DON'T KNOW

Please elaborate on your answer -

WOULD YOU LIKE TO MAKE ANY OTHER COMMENTS OR EXPAND ON ANY OF THE ABOVE QUESTIONS?

If so, please use the space on reverse.

APPENDIX E

CROWN-CRISP EXPERIENTIAL INDEX

Surname ..... Age .....

First name(s) .....

Today's date ..... Sex .....

The following questions are concerned with they way you feel or act. They are all simple. Please TICK the answer that applies to you. Don't spend long on any one question.

1. Do you often feel upset for no obvious reason? YES/NO

2. Do you have an unreasonable fear of being in enclosed spaces such as shops, lifts, etc? OFTEN/SOMETIMES/NEVER

3. Do people ever say you are too conscientious? YES/NO

4. Are you troubled by dizziness or shortness of breath? NEVER/OFTEN/SOMETIMES

5. Can you think as quickly as you used to? YES/NO

6. Are your opinions easily influenced? YES/NO

7. Have you felt as though you might faint? FREQUENTLY/OCCASIONALLY/NEVER

8. Do you find yourself worrying about getting some incurable illness? NEVER/SOMETIMES/OFTEN

9. Do you think that "cleanliness is next to Godliness"? YES/NO

10. Do you often feel sick or have indigestion? YES/NO

11. Do you feel that life is too much effort? AT TIMES/OFTEN/NEVER

12. Have you, at any time in your life, enjoyed acting? YES/NO

13. Do you feel uneasy and restless? FREQUENTLY/SOMETIMES/NEVER

14. Do you feel more relaxed indoors/ DEFINITELY/SOMETIMES/NOT PARTICULARLY

15. Do you find that silly or unreasonable thoughts keep recurring in your mind? FREQUENTLY/SOMETIMES/NEVER

16. Do you sometimes feel tingling or pricking sensations in your body, arms or legs? RARELY/FREQUENTLY/NEVER

17. Do you regret much of your past behaviour? YES/NO

18. Are you normally an excessively emotional person? YES/NO

19. Do you sometimes feel really panicky? NO/YES

20. Do you feel uneasy travelling on buses or the Underground even if they are not crowded? VERY/A LITTLE/NOT AT ALL

21. Are you happiest when you are working? YES/NO

22. Has your appetite got less recently? NO/YES

23. Do you wake unusually early in the morning? YES/NO

24. Do you enjoy being the centre of attention? NO/YES

25. Would you say you were a worrying person? VERY/FAIRLY/NOT AT ALL

26. Do you dislike going out alone? YES/NO

27. Are you a perfectionist? NO/YES

28. Do you feel unduly tired and exhausted? OFTEN/SOMETIMES/NEVER

29. Do you experience long periods of sadness? NEVER/OFTEN/SOMETIMES

30. Do you find that you take advantage of circumstances for your own ends? NEVER/SOMETIMES/OFTEN

31. Do you often feel "strung up" inside? YES/NO

32. Do you worry unduly when relatives are late coming home? NO/YES

33. Do you have to check things you do to an unnecessary extent? YES/NO

34. Can you get off to sleep alright at the moment? NO/YES

35. Do you have to make a special effort to face up to a crisis or difficulty? VERY MUCH SO/SOMETIMES/NOT MORE THAN ANYONE ELSE

36. Do you often spend a lot of money on clothes? YES/NO

37. Have you ever had the feeling you were "going to pieces"? YES/NO

38. Are you scared of heights? VERY/FAIRLY/NOT AT ALL

39. Does it irritate you if your normal routine is disturbed? GREATLY/A LITTLE/NOT AT ALL

40. Do you often suffer from excessive sweating or fluttering of the heart? NO/YES

41. Do you find yourself needing to cry? FREQUENTLY/SOMETIMES/NEVER

42. Do you enjoy dramatic situations? YES/NO

43. Do you have bad dreams which upset you when you wake up? NEVER/SOMETIMES/FREQUENTLY

44. Do you feel panicky in crowds? ALWAYS/SOMETIMES/NEVER

45. Do you find yourself worrying unreasonably about things that do not really matter? NEVER/FREQUENTLY/SOMETIMES

46. Has your sexual interest altered? LESS/THE SAME OR GREATER

47. Have you lost your ability to feel sympathy for other people? NO/YES

48. Do you sometimes find yourself posing or pretending? YES/NO

PLEASE CHECK THAT YOU HAVE ANSWERED ALL THE QUESTIONS

APPENDIX F

PARTICIPANT OBSERVATION CHECK LIST

Mother's number.....

Baby's date of birth.....

Postnatal depression symptoms	First mention by:		
	Client	H.Visitor	Researcher
1. Diet			
2. Sleep			
3. Loss of weight			
4. Irritability			
5. Physiological changes			
6. Anxiety			
7. Appearance			
8. Baby problems			

Tape commenced:

Tape ended:

APPENDIX G

POSTNATAL PROJECT
NOTES TO MOTHERS ABOUT THE DIARY.

If you have any days when you feel anxious or depressed during the next six months, I would be very grateful if you could write down the times and dates, in the attached small notebook. Please could you also mention why you think you felt like this, for how long, and anything you were able to do about it.

I will come back and collect the diary in about six months time on .....

Please do not worry if you are unable to complete the diary or you loose it etc, as I will still come and see you and we can talk about how you have felt.

Deborah Hennessy Investigator

APPENDIX H

Portsmouth and S.E.Hants Health
District,
Western Sector,
133 Stoke Road,
GOSPORT.
Hants.

May 1981

Dear (Health Visitor),

Postnatal Project

Your earlier contribution to this study was very valuable and all the comments will be used in the final analysis. I had an excellent response to the first recording schedule with many health visitors and mothers participating. This led to a large total sample of around 400 mothers. You may have heard that I took a random sample of 60 mothers from this total. I interviewed these 60 mothers with their health visitors, during a routine home visit six months postpartum.

My study is longitudinal and the collection of information will only be completed in September 1981. However I thought that you would be interested to know that my preliminary results suggested that health visitors thought that 20% of postnatal mothers were vulnerable, or "at risk", of developing depression. Although these are not my final results this finding indicated that health visitors were anticipating a lower incidence of postnatal depression than other studies have actually measured.

I will be most grateful if you could help me again in the next stage of the project, by completing the attached questionnaire as soon as possible. Please answer whatever you can from your records, and if you do not know the answers it is not necessary to make a home visit, simply record 'do not know'.

When you have completed the questionnaire please return it to me in the envelope provided via internal mail, after erasing the mother's name. I would be grateful if you could also return any questionnaires that you are unable to complete.

Thank you very much for all your help.

Yours sincerely

Deborah Hennessy

POSTNATAL PROJECT
HEALTH VISITOR RECORDING SCHEDULE 2

Mother's name and address in pencil:

1. Mother's number: .....

2. Baby's birth date: .....

3. Name of GP: .....

   Name of Health Visitor: .....

4. The family have moved out of Portsmouth Health District. YES/NO/DON'T KNOW

5. The family have moved address unknown. YES/NO

6. The family have moved to another address in Portsmouth Health District. YES/NO

7. Please supply the family's new address if known.

   .....

   .....

8. How many contacts have you had with this mother since the baby was born? (If you do not know, clinic visits approximately.)

9. How many of your contacts were home visits (include Birth visit)?

10. If you have the information please record your number of clinic contacts.

11. Do you know how often this mother has been seen by another health visitor (attached or relief)?

    Number of Home visits

    Number of Clinic contacts

12. Do you think this mother has had more than average health visiting? YES/NO

If you answered YES please explain why.

13. In your professional opinion has this mother had postnatal depression since the baby was 6/52 old? YES/NO/DON'T KNOW

If you answered NO please proceed to Q22.

If you answered YES please continue below.

Approximately when do you think this mother had 'postnatal depression', and for how many weeks did it last?

.....

.....

Did any of the following factors lead to your assessment of postnatal depression?

14. Any sleep disturbances? YES/NO

If YES please expand.

15. Any weight changes? YES/NO

If YES please expand.

16. Mother's attitudes to herself. YES/NO

If YES please expand.

17. Mother's attitude to her baby. YES/NO

If YES please expand/

18. Mother's attitudes to her husband. YES/NO

If you answered YES please expand.

19. Mother's attitudes to others. YES/NO

e.g. Relatives/Primary health care team. (Please circle relevant people and expand below.)

Were there any other factors that lead to your assessment of postnatal depression? YES/NO

If YES please expand below.

20. Has this mother been seen by any other Health and Social Service Professional with postnatal anxiety or depression? Whom? YES/NO/DON'T KNOW

21. In your opinion has this mother postnatal depression now? YES/NO

22. Has this mother been involved with any postnatal groups? YES/NO/DON'T KNOW

Please state which one,
e.g. MAMA, NCBT, Postnatal Support Groups, etc.

23. When was your last contact with this mother?

Date: .....

e.g. late February, early May.

24. Have you any other comments - especially if you have felt uneasy at times, etc.

APPENDIX J

Portsmouth and S.E.Hants Health
District,
Western Sector,
133 Stoke Road,
GOSPORT.
Hants.

June/July 1981

Dear (Mother) ,

Postnatal Project

You may remember that shortly after your baby was born your health visitor asked you if you would be prepared to help us, in the Postnatal Project, by answering a few extra questions at that time. You were amongst the 400 mothers in the Portsmouth Health District who did help us, and thank you very much for doing so.

We want to know more about mothers in the year after they have had a baby. Now that your baby is a year old I would be very grateful if you could help us again by completing the attached questionnaire.

You will notice that there is a number instead of your name on the questionnaire, this is to ensure confidentiality.

Thank you very much for participating in this project, it is coming to an end and I will not be contacting you again.

Yours sincerely

Deborah Hennessy Investigator and Health Visitor

APPENDIX K

POSTNATAL PROJECT
MOTHERS' QUESTIONNAIRE

1. Mother's number: .....

2. Baby's birth date: .....

3. What was your baby's birth weight? .....

4. During the past year have you been to any Groups especially for mothers? YES/NO

   If you answered YES please circle the Groups attended.

   New mothers group

   Church group

   National Childbirth Group

   Meet a Mama group

   Mothers and Toddlers group

   Regular coffee with friends

   Other - please specify

5. If you have had any problems with your baby whom did you ask for help?

   Plese circle and complete.

   Baby's grandparents, who? .....

   Husband

   Other family members, who? .....

   Neighbours

   Doctor

   Health Visitor

   Others, who? .....

6. a. Have you had a time since the baby was born when you were more anxious or depressed than the rest of the year? YES/NO

   If you answered NO proceed to Q7; if you answered YES please continue below.

   b. Can you remember when you felt depressed or anxious? Please write down the times, e.g. beginning March or

end April.

c. How long did this last? Please circle correct answer.

A few days / a few weeks / longer

d. During this time did you have any of the following problems?

Sleep

Weight

A feeling of being constantly tired

Feeling very tearful

Feeling very irritable

Feeling very different from normal self

Or any other symptoms - please expand

7. a. If you have had any problems with yourself who did you ask for help?

Baby's grandparents, who? .....

Husband

Other member of family, who? .....

Neighbours

Doctor

Health Visitor

Others, who? .....

b. How near does the person 7a. live to you?

Less than 5 miles away

More than 5 miles and under 50 miles

More than 50 miles

c. Is your own mother still living? YES/NO/DON'T KNOW

If you answered YES does she live:

Less than 5 miles away

More than 5 miles and less than 50 miles

More than 50 miles away

Can you contact her by telephone? YES/NO

8. Do you think you will bring up your baby in the same way that your mother brought you up? YES/NO

Please could you expand on your answer.

9. Has your husband/baby's father changed at all in the year since the baby was born? YES/NO

Please expand on your answer.

10. Have you any other comments to make about this study?

Thank you so much for completing this questionnaire - now please put it in the stamped addressed envelope enclosed and post it back to me.

APPENDIX L

Portsmouth and S.E.Hants Health
District,
Western Sector,
133 Stoke Road,
GOSPORT.
Hants.

September 1981

Dear (Health Visitor),

Postnatal Project

I have had an excellent response tothe recording schedulesand questionnaires that I sent out to health visitors and mothersduring May/June and July this year. Thank you very much for your part in this.

This letter is my last request concerning the present project and has been suggested by many health visitors who have been participating.

I would be grateful if you could pass the accompanying letter and recording schedule to the relevant family practitioner for completion; when the schedule has been completed please return it to me in the enclosed envelope via internal mail.

It will be helpful if all the questionnaires could be returned before the end of September, even if not completed for any reason.

Once again I would like to thank you for all the help you have given me in this large project.

Yours sincerely

Deborah Hennessy

APPENDIX M

Portsmouth and S.E.Hants Health
District,
Western Sector,
133 Stoke Road,
GOSPORT.
Hants.

September 1981

Dear Dr ,

Postnatal Depression Project

The Postnatal Depression Project is funded until November 1982 by the Wessex Regional Health Authority
and is now in the final stage of information collection. The entire study is under the supervision of Southampton University and is also approved by the Ethical Committee of the Portsmouth and South East Hants Health District.

I have a randomsample of about 400 women inthis district whoallagreed toparticipate inthe project.
The health visitors concerned have completed questionnaires on these women at four intervals since the mothers´ confinements about May/June 1980. About one-third of the sample of mothers have also completed psychometric tests at different intervals during their pregnancies and postnatal months.

I have been most careful to maintain the highest standards of confidentiality and you will note that the mother´s name and her code number are not on the same page.

I should be most grateful if you would be prepared to help in the final part of the projectby completing the attached questionnaire pertaining to MRS....., Date of Birth.....Baby born on.....

Thank you very much for your co-operation.

Yours sincerely

Mrs D A HENNESSY BA.,SRN., SCM., HV. Cert.
Investigator/Health Visitor

APPENDIX N

POSTNATAL PROJECT

Mother's No. .....

1. Has this lady consulted you during the year since her baby was born? YES/NO

2. Has this lady consulted you with any problems during this time which in your opinion were postnatal depression? YES/NO

If you answered YES to 2, please continue.

3. Can you give me the approximate date/s of consultations?

.....

.....

4. Can you recall any specific symptoms? YES/NO

If you answered YES, what symptoms?

.....

.....

.....

5. Did you prescribe any medication? YES/NO

6. Did you refer to a psychiatrist? YES/NO

Have you any further comments you wish to make?

.....

.....

.....

.....

.....

Your attached health visitor will return this to me.

CASE HISTORY

HEALTH VISITOR RECORDING SCHEDULE 1

PART A

HEALTH VISITOR: 0572
(or Relief Health Visitor's No.)

DATE OF:

MOTHER'S BIRTH 4.6.49

CASE NO. 3

BABY'S BIRTH 13.5.80

BABY'S CODE NO: 02578

LEGAL STATUS: MARRIED 1.5.71

ANY MISCARRIAGES: NO

BIRTH DATES OF PREVIOUS LIVE CHILDREN: NONE

BIRTH AND DEATH DATES OF DECEASED CHILDREN: NONE

DATE OF STILLBIRTHS: NONE

1. Has the mother suffered with dysmenorrhoea in the last 3 years? YES

2. Husband/Cohabitee's Occupation: Maintenance Fitter

   For the cohabitating mother, is this a continuing relationship? YES

   Hsve you any other relevant information regarding the above question? If so, give details on reverse.

3. Does this mother have a predominantly good relationship with her partner? YES

4. Mother's occupation prior to childbirth: Computer Operator

5. Type of accommodation: Terrace House

6. Is ther any help available from the extended family? e.g. mother, mother-in-law - or any other. NO

7. How long have you known this mother?
   Did you have any contact with her during pregnancy?
NO

8. Did the mother attend Mothercraft classes during this pregnancy? YES - ONE ONLY

9. Does the midwife think this mother will develop postnatal depression? DON'T KNOW
   If you answered 'YES', what reason was given by the midwife?

PART B

AFTER PRIMARY BIRTH VISIT

Date of Visit: 30.5.80

1. Type of pregnancy: NORMAL

2. If a complicated pregnancy, please give details.

3. Type of delivery: FORCEPS

4. a. Length of delivery: Stage I 16 hours
   Stage II 1 hour 15 minutes
   Stage III 5 minutes

   b. Was husband/cohabitee present at delivery? NO

5. a. Has the puerperium been normal/complicated? YES

   b. Please give details of any complications. Haemorrhage

6. a. Have there been, or are there any problems with the baby? YES

   b. Please give details of any problems. Wakeful during day. Frequent crying though not hungry.

7. Has breast feeding been attempted? YES

8. Has breast feeding been established? YES

9. Do you think this mother is likely to develop postnatal depression? YES

10. Please could you give the reason for reply to Question 9 and/or make any other relevant comments. Unsure and tearful.

PART C

CHOSEN TYPE OF CONTRACEPTION: Coil

6-WEEKS POSTNATAL INTERVIEW: Date of Interview: 26.6.80

1. REPORTED PHYSICAL CHANGES

a.	Has the mother's appetite decreased?	NO
b.	Is she attempting to lose weight?	YES
c.	Has she lost weight?	YES
d.	Is her weight loss more than would normally be expected after birth of baby? (If known, please give the approximate amount of weight loss.)	YES approx 14 lbs
e.	Is the mother constipated?	YES
f.	Is mother's speech obviously slower than expected?	NO

2. REPORTED SLEEP CHANGES

a.	Can she get to sleep at night?	YES
b.	At night, does she wake at times other than when the infant cries?	NO
c.	Does she wake early in the morning and find it difficult to go back to sleep?	NO
d.	Does she have any other sleep disturbances?	NO

3. MOTHER'S REPORTED MOOD

a.	Is the mother 'fed up'?	NO
b.	Is she unhappy with good reason, i.e. trouble with baby, bereavement, husband?	NO
c.	Is she unhapy without an obvious reason?	NO
d.	Does the mother have crying spells?	NO
e.	Does mother feel a great change in libido/sexual desire?	DON'T KNOW

4. MOTHER'S REPORTED FEELINGS ABOUT HERSELF

a.	Does the mother feel positive about herself?	YES

b. Is her general attitude to life positive? YES

c. Does she criticise herself? YES

d. Can she make decisions? YES

e. Does mother feel her appearance is neglected? NO

NOTE: WHERE THE WORD 'HUSBAND' APPEARS, WHERE APPROPRIATE PLEASE READ 'SEXUAL PARTNER'

5. MOTHER'S REPORTED RELATIONSHIP WITH HER HUSBAND SINCE THE BIRTH

a. Has mother's emotional attachment to her husband changed? YES

b. Is she less attached to husband than she was before the birth? NO

c. Is she more attached to husband than she was before the birth? YES

d. Does father assist the mother? YES

6. HEALTH VISITOR'S OBSERVATIONS AND MOTHER'S REPORTED RELATIONSHIP WITH HER BABY

a. Have the baby and mother been separated at all? e.g. mother into hospital without baby, or baby in hospital without mother? NO

b. Are the baby and mother together now? YES

c. Does the mother feel she is relating well with the baby? YES
Does your professional judgement support this answer? YES

d. Is the mother trying to respond to the demands of her baby? YES
Do your observations support this answer? YES

e. Does the mother feel she can cope with her responsibilities? DON'T KNOW

f. Can the mother cope with her baby? YES

7. BABY SECTION

a. Has the baby had any problems? e.g. prematurity, low birth weight, congenital, etc. NO

b. Has the baby had any feeding problems? NO

c. Has the baby any illness, e.g. thrush, etc. NO

8. THE HEALTH VISITOR'S IMPRESSION ABOUT THE MOTHER'S INTERACTION WITH THE COMMUNITY

a. Is she meeting other people? YES

b. Is the mother avoiding other people, e.g. not going out? NO

c. Is the mother making excessive demands on husband? NO

d. Is mother making excessive demands on other members of the family? NO

e. Is mother making excessive demands on health visitor/or Primary Health Care Team? NO

9. HEALTH VISITOR'S OBSERVATIONS ON MOTHER'S APPEARANCE

a. Does the mother look anxious or unhappy? NO

b. Does the mother look at you when she talks to you? YES

c. Does mother's posture have a confident appearance? YES

d. Is mother's personal appearance and grooming neglected? NO

10. HEALTH VISITOR'S PROFESSIONAL OPINION

a. In your opinion, has this mother had postnatal depression during the past 6 weeks? YES

b. In your opinion, does this mother have postnatal depression now? NO

c. Has she been referred to GP/psychiatrist for this problem? NO

d. Is this mother taking any drugs at all? NO
State which drugs.

e. Do you think this mother may develop postnatal depression during the subsequent weeks? NO
Please elaborate on your answer. Attends New Mothers Group and appears settled now.

TAPE RECORDING OF THE SIX MONTH HOME VISIT

A mother from the Participant Observation Group.

(This interview has been transcribed in its entirety, but names and dates have been altered to maintain anonymity.)

HV It is very good.

M I usually have tea at this time anyway; he usually has something as well.

HV I must admit that, when I telephoned you, you must have been a bit mystified - may I try one of these?

M Yes, do.

HV Because I said breast-feeding survey - these are very nice.

M I am not much of a cook but I do try.

HV And of course it is not, it is the one dealing with feelings after childbirth.

M Oh, yes, that is right.

HV Because we had two things going in close succession and Mrs Hennessy is doing this one and really it is only that there will be a few questions at the end, that she might like to ask you, otherwise it is just an ordinary visit really because I would have probably been coming anyway, as John is now eight months, and it will be time for his Hearing Test soon.

M Oh, that is right, yes.

HV Roughly about nine months; I will send you an appointment for that; it will probably be a Monday morning; will that be alright?

M Yes, that is fine.

HV Right, we'll do that; we are not lucky with seeing our babies today - although they are not babies anymore. I haven't seen John

for a little while.

M No he won't be - he doesn't stay up for long.

HV I expect I shall see a difference in him.

M Yes, he is a big boy.

HV What sort of things is he doing now?

M Well, he is in to everything now.

HV Crawling?

M Yes; he says 'Mum' and 'Dad' and that sort of thing. He shouts a lot; he is quite happy actually; he is a little bit lonely I think, you know, he needs other little children around.

HV it is quite a quiet street this, isn't it? We were commenting on this, because it is not a through road. You have to turn at the end.

M Yes.

HV You do get a lot of lorries don't you?

M Yes, dreadful.

HV But you don't get ordinary traffic through?

M No; we have got a little playgroup going on this road because there are so many babies - five babies born last year. So, one of my neighbours got the cricket club - do you know the cricket club at all?

HV I don't actually, but is it in the park there?

M Yes; we have got one room there.

HV Really?

M So we can get together on a Wednesday afternoon.

HV That is interesting.

M It is more of a babysitting circle really, you know.

HV Like a mother and toddler group?

M Yes, but different ages; there are babies and under three year olds.

M Well it gives somebody a break if they want to, you know, to do a bit of shopping. I mean they can do what they like; it is very basic - there is nothing there; we have to do our own thing in it really.

HV Is it just from this road?

M Oh yes, just from this road - there is enough. The room is not very big actually so ...

HV But that is how you start isn't it?

M Yes; because we don't really know each other around here; we tend to - well I do anyway - I tend to keep to myself - and so do the other people so we thought, well, we couldn't go to a house, as there are too many children, so we thought we would get the pavilion.

HV Was that Mrs ..... Now I have got Mrs ..... with Daniel; did she start the idea?

M No, another lady down the road; her husband works for the Council actually; he probably suggested it; her children are five and three and she has only just moved in anyway.

HV Where from?

M North.

HV I am not sure whether ...

M Sheila - gosh, I don't know her second name.

HV There is Mrs ..... across the road up the other way.

M Oh, yes she has got a little boy.

HV Does she go?

M No.

HV She came to the new mothers group butmaybe she is following that up with people she met there.

M I don't know, but I never see her.

HV Mrs .....

M Yes, she comes.

HV Mrs .....

M No, my mother lives up the same road; that's the lady with the dog.

HV She doesn't seem interested?

M Well people feel that she has got her horses and her dog, that she doesn't have much time for anything else, you know, but if I get an opportunity to see her I will ask.

HV Yes, do; because I think possibly it could benefit her.

M Yes, she seems a little bit shy.

HV Yes she does; well that is very interesting. Have you heard of the Playgroup Association; there is a National Playgroup Association.

M No.

HV And things like the Mother and Toddler Groups come under the umbrella of this and it is just that you can gain a lot of benefit by being in contact with them in the sense that you may possibly be able to borrow toys and things like that; if you are ever interested, I could put you in touch.

M We have quite a lot of toys actually; we have the 'throw-outs' and we take them up there you know.

HV Can you make a cup of tea up there or anything?

M Oh yes; the park keeper looks after the room for us. We pay £2 a session which after all isn't too bad really but there is hot water there.

HV Well this is most interesting.

M Someone did tell me that the Toddler Group up in the town only did take toddlers not babies.

HV Not actually so, but I would think it likely that you would get more toddlers than mothers with single babies. You would perhaps have mothers with a baby and a toddler going with the toddlers to play but not so much a baby on their own.

M Someone made some enquiries about it.

HV There is certainly a need for people with children under three years - under the playgroup age.

M I think so, especially one child like me, but he doesn't see children at all you see.

HV That's right; and even when he is a bit bigger there isn't a playgroup here. This whole area here right down into the next village is completely devoid of anything partly because there is no hall and no facilities at all.

M That's right. Well ours is small but it serves our purpose. Well, the hockey club is new but we really didn't want to take the children in there - they would probably demolish the place. You want somewhere where you don't have to worry about them breaking the place up and that is why we didn't want to have it in people's homes.

M Yes - hundreds! It seems like it sometimes. Yes, I have had to give up the breast feeding now because ...

HV Well you have done very well.

M Seven months I suppose.

HV Just think how worried you were initially.

M Oh yes.

HV You came through that - that was very good and you have fed all this time. We started a new mothers group yesterday and it was rather good talking to them because they were all breast feeding, I am happy to say.

M That's unusual.

HV Yes, I was very pleased about that.

M Well I found it very good - well it was certainly good for him.

HV You are very interested aren't you? Well hopefully you will be coming to see me anyway and we will play when you come for your Hearing Test. You are thinking aren't you? If only we could get inside their mind.

M Marvellous isn't it?

HV Oh you are going to talk to us; what are you going to say - what shall we talk about? Mum-mum-mum; Dad-dad-dad. What can James say? Are you pulling up now?

M He doesn't actually sit up - I don't know why. He crawls quite well - he rolls along, but he doesn't actually sit up on his own - it is funny isn't it?

HV What's he like if you put him there?

M Well, he falls.

HV Does he? Sit up - let's have a look; no he can't. How long does he stay like that or does he go down sideways?

M Yes he does, he just falls; when I put him in the pram I strap him in. He doesn't actually pull himself up to sit you know. I thought by now he would have been.

HV Yes, but then is he happier when he is on his tummy?

M Yes, he seems to like it there.

HV Well then, let's see what he does.

M He is teething at the moment.

HV Does he wriggle his way along or ...?

M Yes.

HV He doesn't really crawl?

HV Look at that, you see? That's fine isn't it?

HV It's just the actual sitting - he is very nearly there. Is that a new trick?

DH I bet your daddy taught you how to do that.

HV Ah, you can certainly go when you see something you want - he is after you. Does he roll over?

M Yes, he just rolls along or he shuffles; he gets around on that thing of course.

HV He likes that does he?

M Yes, he seems to.

HV He propels it with his feet.

M Yes.

HV It would probably be a good idea to let him practise sitting quite a bit so as to strengthen here; it may well be that he has got a wee bit used to being supported ...

M ... on that.

HV And not having to do it himself; so I should encourage him for little periods during the day to sit with you. If you can get him

engrossed in something that he likes doing then perhaps he will forget that he is actually sitting. Has daddy taught you how to make funny noises? They are the culprits these days aren't they?

M They shout at each other a lot.

HV Or blow raspberries?

M That's right.

HV Oh dear, that was a bit of a surprise for you wasn't it? Don't worry - that's right. It's not easy is it? What are you going to do to get there? Is someone going to help you or not - now let's just see.

M Where are your toys James? Look.

HV Ah - he is trying very hard - children are fascinating. What is he like feeding now?

M He is very good.

HV Eating your own foods now?

M Yes - everything - well most things; he is certainly eating more now than he has ever done. At first I was a bit worried, because he didn't seem to eat very much but ...

HV Well you have been feeding him so that's why.

M Yes, but now of course he is on cows milk all the time.

HV And is he sleeping at night?

M Well, he sleeps from about 6 p.m. to 5.30 a.m.

HV Oh well, that's good.

M So it is not too bad.

HV Is there anything you want to ask?

DH I am following up 60 mothers etc ...

For instance you have just told us that you had a pretty grotty five month period and it sounded as if you had sorted out what to

do.

M Well, you do sometimes. At first I used to ring up my husband and say "oh come home" and he did about three times I suppose and then I thought I can't keep doing that you know, that's no good so I asked my mother if she would come and she wouldn't so that was that. So I thought, well that's it, I'm on my own so I have just got to get on with it; I wouldn't involve my neighbours or anybody else, I am not that sort of person; I just like other people knowing.

HV Why did she say she wouldn't? Was it because she felt that you must get on with it, or that she just couldn't?

M Well she could have come as they are retired you know, but I didn't tell her how I felt, I just said "would you come and stay with me for a while?" and she said "no". I felt I would have liked somebody like my mother rather than somebody else, you know. I suppose it is just one of those things isn't it? I feel a little bit resentful you know. I wanted to cry on someone's shoulder really.

HV Have you been able to talk about that with her since?

M No. We are not terribly close actually and I have been away for so long now that we have sort of lost touch, you know.

HV Are they local?

M No, no; they live in Wales.

HV Oh yes; that's a long way.

M I have been away about 12 years I suppose.

DH .....

M No, possibly not, but at the time I thought "why not, why can't she come?". I didn't see it like that you know; I think you just need

somebody to say "you are doing alright". Although you have no confidence I felt I wanted somebody to tell me "look, that's great, you are doing fine", just somebody to give me a little bit of a boost or something like that. I mean when I started him on solid food, I felt I needed somebody to tell me that I was doing the right thing.

HV You didn't ring me up!

M Well no ...

HV ... well, actually you did.

M ... yes, I did come up to the clinic but you want somebody there with you, if you know what I mean, to say "look you are doing alright".

HV Yes you want them there - well not exactly all the time, but at the time you need them.

M Yes I felt at each step I wanted someone behind to say "well you are alright - you are doing fine" and then suddenly you get to a point that you think you have just got to get on with it, there is nobody going to be there telling you you are doing well, so you get more confidence I suppose and you take things more in their stride rather than worrying about them.

HV Yes 'cause success brings success is a very true thing and the more you find you can do the better it will be and you find you can cope. You musn't feel ... You can always just shout and say "I don't know about this one" - come and tell me won't you?

M Yes I will.

HV Did you find the group helped?

M In some ways, I think more on the professional advice you know rather than the people; I cannot communicate with people that well,

you know, but I took it all in.

HV It gave you the basics?

M Yes, that's right.

DH I am going to come back and see you when your baby is a year old or a little bit over - if that is alright?

M Yes fine.

DH I will just send you a letter to say that I will be coming on such and such a date and obviously if it is inconvenient just let me know.

M Yes.

DH If you have lost this ... etc.

DH I would just like to ask one other question - would you say then that you had postnatal depression?

M Yes, definitely - I have never had depression like that before - it's totally different - I mean I have been depressed but not nearly like I was - totally different.

DH Do you still get upset about this?

M Sometimes I do, yes. I thought I was going to do so well, you know, and well I just felt ...

HV ... it was a disappointment to you?

M Yes it was; I felt it was a shame it happened and you never think it is going to happen to you but I wont say it was good, but I hope it wont happen again - I must admit that. It is nothing physical - no pain or anything but I hope it never does happen again. I think it would probably be the same again coping with it.

HV Would it put you off having any more children?

M Um ... yes, I must admit, at first, yes; but I am not sure now whether it is because of that, or for other reasons, that I would

have any more children. I feel sometimes that I am a little bit old - really we were a little bit too old to start a family I suppose. I always felt that if I had been younger I would have been able to cope better because you don't worry so much you know, that was my argument against it anyway. I think when you are younger you take things more in your stride and when you are older and you have been married for so long, things are different - they are harder to adjust to.

HV Adjust to, yes.

M And we have always moved around so much and now we are tied - I think it is because we feel restless.

HV How has your husband adjusted to this?

M He has been very good actually; he has been very patient you know; he enjoys the baby; he loves having the baby, but of course our sex life is not the same, you know, and it has taken me a lot longer to feel the same about sex and that has taken a long time; it has taken me what seven months and it is still not really feeling the same.

HV Do you feel this is more mental than physical?

M Probably, yes. But he is very understanding you know and of course up until now I have felt really tired most of the time so I have given up breast feeding and I was losing weight all the time. I just couldn't gain weight.

HV Yes, you did lose weight, didn't you?

M Yes, terrible and now I feel a little more energetic.

HV More yourself?

M Yes.

DH And sleeping - how do you sleep?

M Quite well.

DH Can you get to sleep at night?

M Yes, usually.

HV Unless he wakes you up?

M Yes, I don't mind really.

DH Well I just hope I haven't upset you by asking these questions? Are you going to ring up your husband now?

M No he will probably ring me; he has always done that. He has felt as well that he likes to keep in touch.

DH Well that's lovely.

M At first, when I was really so depressed, he would say "do you want me to come home or anything?"; and I said "no, as long as you ring me, I feel that much better"; if anything did go wrong, then knowing that he was going to ring at 11 o'clock so I could pour it out then and feel that much better.

DH So this is for you; as I say you are Mrs 2578.

M It's almost like the Co-op number!

HV I don't know about the dividend though!

M Shall I start keeping it now until you visit me?

DH That would be grand, yes; and if you would like to jot down a little bit of the past; you see it is a very little book so I am not really asking for too much because I don't want to use too much of your time etc.

HV Well thank you very much for your time.

DH It is very hard to find a notebook that size so I have been making my own. Smaller ones are almost impossible to get (discussion on exercise books).

Well thank you very much indeed for participating in this project.

M Well, I hope it will help somebody else eventually.

DH I am sure it will.

M You see you are always aware of these things but when they happen to you it´s different.

HV ... it´s hard to do so without making mothers anxious anyway; it´s no good really saying ..... and those perhaps who wouldn´t at all, saying "goodness me what is this going to be like" so.

POSTNATAL PROJECT

HEALTH VISITOR RECORDING SCHEDULE 2

1. Mother's number 2578

2. Baby's birth date 13.5.80

3. Name of GP

   Name of Health Visitor

4. The family have moved out of Portsmouth Health District. NO

5. The family have moved address unknown. NO

6. The family have moved to another address in Portsmouth Health District. NO

7. Please supply the family's new address if known.

8. How many contacts have you had with this mother since the baby was born? (If you do not know, clinic visits approximately.)

9. How many of your contacts were home visits (include Birth visit)?

10. If you have the information please record your number of clinic contacts.

11. Do you know how often this mother has been seen by another health visitor (attached or relief)?

    Number of Home visits

    Number of Clinic contacts

12. Do you think this mother has had more than average health visiting? NO

    If you answered YES please explain why.

13. In your professional opinion has this mother had postnatal depression since the baby was 6/52 old? YES

    If you answered NO please proceed to Q22.

    If you answered YES please continue below.

    Approximately when do you think this mother had 'postnatal depression', and for how many weeks did it last?

    May-June

DID ANY OF THE FOLLOWING FACTORS LEAD TO YOUR ASSESSMENT OF POSTNATAL DEPRESSION?

14. Any sleep disturbances? YES

If YES please expand.

Reported waking more often.

15. Any weight changes? YES

If YES please expand.

Weight loss greater than normal.

16. Mother's attitudes to herself. YES

If YES please expand.

Much self-doubt, inability to cope.

17. Mother's attitude to her baby. NO

18. Mother's attitudes to her husband. NO

19. Mother's attitudes to others. NO

e.g. Relatives/Primary health care team/others

(Please circle relevant people and expand below.)

Were there any other factors that lead to your assessment of postnatal depression? YES

If YES please expand below.

Appeared slow in movement and detached in conversation.

20. Has this mother been seen by any other Health and Social Service Professional with postnatal anxiety or depression? NO

21. In your opinion has this mother postnatal depression now? NO

22. Has this mother been involved with any postnatal groups? YES

Please state which one,
e.g. MAMA, NCBT, Postnatal Support Groups, etc.

Postnatal Support Groups.

23. When was your last contact with this mother?

Date: January 1981

e.g. late February, early May.

24. Have you any other comments - especially if you have felt uneasy at times, etc.

NO

INFORMATION FROM - HEALTH VISITORS' RECORDS, ONE YEAR POST- CONFINEMENT

This health visitor was using records which were being piloted in the health district at that time to assist health visitors when working within the Nursing or Health Visiting Process system. This system included separate records for the baby, other members of the family, and the family 'needs or problems'. The author read each record to find all the information that had anything to do with the mother; there was very little information recorded about the mother and it is all noted below.

Baby's Record Card.

26.6.80 Baby feeding and sleeping well. Mother suddenly feels more positive and in better health this week. Mother appears relaxed.

18.1.81 Follow-up of survey, see 1 month. (This was the observed visit)

No further visit was recorded.

There were no comments about the mother on the Family or the Needs/ Problem record, nor on any other records. The author found this lack of recording rather disappointing as the health visitor must have gathered considerable information about the mother, especially during the 'observed' six-month postpartum interview.

POSTNATAL PROJECT

MOTHERS' QUESTIONNAIRE

1. Mother's number: 2578

2. Baby's birth date: 13.5.80

3. What was your baby's birth weight? 7.6

4. During the past year have you been to any Groups especially for mothers? YES

   Regular coffee with friends.
   Mothercraft group.

5. If you have had any problems with your baby whom did you ask for help?

   In-laws.
   Husband.

6. a. Have you had a time since the baby was born when you were more anxious or depressed than the rest of the year? YES

If you answered NO proceed to Q7; if you answered YES please continue below.

b. Can you remember when you felt depressed or anxious? Please write down the times, e.g. beginning March or end April.

   May until end of July.

c. How long did this last?

   A few weeks.

d. During this time did you have any of the following problems?

   Sleep

   Weight

   A feeling of being constantly tired

   Feeling very tearful

   Feeling very irritable

   Feeling very different from normal self

   Or any other symptoms - please expand

   Didn't like being alone.
   Couldn't make decisions.

No confidence.
One day cried all day.

7. a. If you have had any problems with yourself who did you ask for help?

Husband.

b. How near does the person 7a. live to you?

Less than 5 miles away.

c. Is your own mother still living? YES

If you answered YES does she live:

Less than 5 miles away

More than 5 miles and less than 50 miles

More than 50 miles away YES

Can you contact her by telephone? NO

8. Do you think you will bring up your baby in the same way that your mother brought you up? NO

Please could you expand on your answer.

My mother was very distant and didn't show love - I try to be more demonstrative.

9. Has your husband/baby's father changed at all in the year since the baby was born? YES

Please expand on your answer.

Even more involved with family.

10. Have you any other comments to make about this study?

Mothercraft class was unsuitable - as I arrived in the middle.
I think that I should have met the Health Visitor before I had the baby.
I found the clinics cold (temperature and atmosphere) - particularly because it's a Health Centre.

Thank you so much for completing this questionnaire - now please put it in the stamped addressed envelope enclosed and post it back to me.

The first time mothers group in the Health Centre was very helpful - but I found it quite frightening.

FAMILY PRACTITIONER RECORDING SCHEDULE

Mother's No: 2578

1. Has this lady consulted you during the year since her baby was born? NO

2. Has this lady consulted you with any problems during this time which in your opinion were postnatal depression? NO

CROWN-CRISP EXPERIENTIAL INDEX

No. 2578

1.	Do you often feel upset for no obvious reason?	NO
2.	Do you have an unreasonable fear of being in enclosed spaces such as shops, lifts, etc?	NEVER
3.	Do people ever say you are too conscientious?	NO
4.	Are you troubled by dizziness or shortness of breath?	NEVER
5.	Can you think as quickly as you used to?	YES
6.	Are your opinions easily influenced?	YES
7.	Have you felt as though you might faint?	NEVER
8.	Do you find yourself worrying about getting some incurable illness?	NEVER
9.	Do you think that "cleanliness is next to Godliness"?	NO
10.	Do you often feel sick or have indigestion?	NO
11.	Do you feel that life is too much effort?	NEVER
12.	Have you, at any time in your life, enjoyed acting?	NO
13.	Do you feel uneasy and restless?	SOMETIMES
14.	Do you feel more relaxed indoors?	DEFINITELY
15.	Do you find that silly or unreasonable thoughts keep recurring in your mind?	SOMETIMES
16.	Do you sometimes feel tingling or pricking sensations in your body, arms or legs?	RARELY
17.	Do you regret much of your past behaviour?	NO
18.	Are you normally an excessively emotional person?	YES
19.	Do you sometimes feel really panicky?	YES
20.	Do you feel uneasy travelling on buses or the Underground even if they are not crowded?	NOT AT ALL
21.	Are you happiest when you are working?	NO
22.	Has your appetite got less recently?	NO
23.	Do you wake unusually early in the morning?	NO
24.	Do you enjoy being the centre of attention?	NO

25.	Would you say you were a worrying person?	FAIRLY
26.	Do you dislike going out alone?	YES
27.	Are you a perfectionist?	NO
28.	Do you feel unduly tired and exhausted?	NEVER
29.	Do you experience long periods of sadness?	NEVER
30.	Do you find that you take advantage of circumstances for your own ends?	SOMETIMES
31.	Do you often feel "strung up" inside?	NO
32.	Do you worry unduly when relatives are late coming home?	YES
33.	Do you have to check things you do to an unnecessary extent?	NO
34.	Can you get off to sleep alright at the moment?	YES
35.	Do you have to make a special effort to face up to a crisis or difficulty?	NOT MORE THAN ANYONE ELSE
36.	Do you often spend a lot of money on clothes?	NO
37.	Have you ever had the feeling you were "going to pieces"?	YES
38.	Are you scared of heights?	VERY
39.	Does it irritate you if your normal routine is disturbed?	NOT AT ALL
40.	Do you often suffer from excessive sweating or fluttering of the heart?	NO
41.	Do you find yourself needing to cry?	NEVER
42.	Do you enjoy dramatic situations?	NO
43.	Do you have bad dreams which upset you when you wake up?	NEVER
44.	Do you feel panicky in crowds?	SOMETIMES
45.	Do you find yourself worrying unreasonably about things that do not really matter?	NEVER
46.	Has your sexual interest altered?	THE SAME OR GREATER
47.	Have you lost your ability to feel sympathy for other people?	NO

48. Do you sometimes find yourself posing or pretending? NO

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 SPSS8 2900 RELEASE 4.2 28/01/81

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 SPSS BATCH SYSTEM

 SPSS FOR ICL 2900, VERSION 4.2(IBM RELEASE 8.1) FEBRUARY 1
0                                    CURRENT DOCUMENTATION
 ORDER FROM MCGRAW-HILL:  SPSS, 2ND ED. (PRINCIPAL TEXT)
                          SPSS PRIMER (BRIEF INTRO TO SPSS)
                          SPSS UPDATE (USE W/SPSS,2ND FOR R
-DEFAULT SPACE ALLOCATION..     ALLOWS FOR..     55 TRANSFOR
 WORKSPACE     38500 BYTES                     220 RECODE V
 TRANSPACE      5500 BYTES                     880 IF/COMPU

                    1 RUN NAME       SEE SURVEYDATA3
                    2 GET FILE       SURVEYDATA3
0
0                              FILE SURVEYDA HAS 222 VARIAB

                               THE SUBFILES ARE..
0                                          NO OF
                               NAME        CASES

                               WHITE         225
                               GREEN          77
                               YELLOW         84
0
0CPU TIME REQUIRED..    0.55 SECONDS


                    3 PAGESIZE       50
                    4 LIST FILEINFO  COMPLETE
1SEE SURVEYDATA3

 FILE   SURVEYDA (CREATION DATE = 16/03/84)
0DOCUMENTATION FOR SPSS FILE 'SURVEYDATA'
0LIST OF THE   3 SUBFILES COMPRISING THE FILE

 WHITE    N=  225   GREEN    N=   77   YELLOW   N=   84
0DOCUMENTATION FOR THE  222 VARIABLES IN THE FILE 'SURVEYDATA'
0REL  VARIABLE  VARIABLE LABEL
 POS      NAME

0  1  SEQNUM
0  2  SUBFILE
0  3  CASWGT
0  4  V1          HVS NO
0  5  V2          HVS COMP NO
0  6  V3          CASE NO
0  7  V4          BABY COMP NO
0  8  V5          BIRTHPLA
                                1. HOSP
                                2. HOME
```

```
                                        3. GP UNIT
0   9   V6          MOTHER AGE
0  10   V7          BABY BIRTH
0  11   V8          MISC-TERM
0  12   V9          STEPCHDRN
0  13   V10         PREV   UNDER 5
0  14   V11         PREV OVER 5
0  15   V12         PREV DECEASED CHDRN
0  16   V13         STILLBIRTHS
0  17   MSOLD
                                        1. SINGLE
                                        2. MARRIED
                                        3. WIDOWED
1SEE SURVEYDATA3

0DOCUMENTATION FOR THE  222 VARIABLES IN THE FILE 'SURVEYDATA'
0REL  VARIABLE  VARIABLE LABEL
 POS      NAME

0  17   MSOLD   \ CONT
                                        4. DIVORCD
                                        5. SEPRTD
0  18   MSNOW
                                        1. SINGLE
                                        2. MARRIED
                                        3. WIDOWED
                                        4. DIVORCD
                                        5. SEPRTD
0  19   V15         DATE CHANGE OF STATUS
0  20   V16         PREV DYSMEN
                                        1. YES
                                        2. NO
                                        3. DK
0  21   V17         HUSBAND OR COHAB
                                        1. HUS
                                        2. COHAB
                                        3. NEITHER
0  22   V18         PARTNER OCCUPATION
                                        1. TITLD
                                        2. PROFESSNL
                                        3. WHT COLLRD
                                        4. SKILL AND SEMI-SKILL
                                        5. UNSKILLD
0  23   V19         CONT RELAT
0  24   V20         GOOD RELAT
0  25   V21         MOTH OCCUPATION
                                        1. TITLD
                                        2. PROFFNL
                                        3. WHT COLLRD
                                        4. SKLLD AND SEM-SKLL
                                        5. UNSKLLD
                                        6. HOUSWF
                                        7. SCHOOLGRL
0  36   V22         TYPE ACCO
                                        1. HOME OWNER
1SEE SURVEYDATA3

0DOCUMENTATION FOR THE  222 VARIABLES IN THE FILE 'SURVEYDATA'
0REL  VARIABLE  VARIABLE LABEL
 POS      NAME

0  36   V22         CONT
```

```
                                    2. RENTED
                                    3. COUN
                                    4. NAVAL
                                    5. CARAVAN
  0  27   V23        HELP AVAILABL
                                    1. MOTHR
                                    2. MOTHR IN LAW
                                    3. SISTR
                                    4. SISTR IN LAW
                                    5. MINIMAL
                                    6. NIL
                                    7. HUSBAND
  0  28   V24        TIME HV KNOWS MOTHER
                                    1. SINCE BABY BIRTH
                                    2. LESS THAN DURNG PREG
                                    3. LONGER THAN ONE YEAR
  0  29   V25        ANTENAT CONTACT
  0  30   V26        ATTEND MOTHERCRAFT
  0  31   V27        MIDWVS PREDICTS
  0  32   MWC1
                                    1. DIFFCLTS IN PUERPER
                                    2. MOTHRS ANXIETOVER SE
                                    3. RELATSHPWITH BABY
                                    4. REL WITH HUSBAND
                                    5. PREV PND OR DEP
                                    6. BABIES IN QUICK SUCC
                                    7. HUSBAND AWAY
                                    8. BABE ADOPTED OR FOST
                                    9. RELATSHP WITH BABYS
  0  33   MWC2
                                    1. DIFFCLTS IN PUERPER
                                    2. MOTHRS ANXIETOVER SE
                                    3. RELATSHPWITH BABY
                                    4. REL WITH HUSBAND
                                    5. PREV PND OR DEP
                                    6. BABIES IN QUICK SUCC
                                    7. HUSBAND AWAY
1SEE SURVEYDATA3

0DOCUMENTATION FOR THE  222 VARIABLES IN THE FILE 'SURVEYDATA'
0REL  VARIABLE  VARIABLE LABEL
 POS      NAME

  0  33   MWC2       CONT
                                    8. BABE ADOPTED OR FOST
                                    9. RELATSHP WITH BABYS
  0  34   MWC3
                                    1. DIFFCLTS IN PUERPER
                                    2. MOTHRS ANXIETOVER SE
                                    3. RELATSHPWITH BABY
                                    4. REL WITH HUSBAND
                                    5. PREV PND OR DEP
                                    6. BABIES IN QUICK SUCC
                                    7. HUSBAND AWAY
                                    8. BABE ADOPTED OR FOST
                                    9. RELATSHP WITH BABYS
  0  35   V29        DATE VISIT
  0  36   V30        PREG TYPEV33,DEL LNGTH
                                    1. NORMAL
                                    2. COMPLIC
  0  37   CD1
                                    1. PET
```

2. CYSTITIS
3. TWINS OR UNDIAGNOS
4. CYSTS OF FIBROIDS
5. PREMAT ORSMLL FR DAT
6. APH
7. INCOMPETENTCX OR UNS
8. UNWELL MOTHER
9. MOTHER FEELINGS

0 38 CD2

1. PET
2. CYSTITIS
3. TWINS OR UNDIAGNOS
4. CYSTS OF FIBROIDS
5. PREMAT ORSMLL FR DAT
6. APH
7. INCOMPETENTCX OR UNS
8. UNWELL MOTHER
9. MOTHER FEELINGS

0 39 CD3

1. PET

1SEE SURVEYDATA3

0DOCUMENTATION FOR THE 222 VARIABLES IN THE FILE 'SURVEYDATA'

OREL POS	VARIABLE NAME	VARIABLE LABEL

0 39 CD3 CONT

2. CYSTITIS
3. TWINS OR UNDIAGNOS
4. CYSTS OF FIBROIDS
5. PREMAT ORSMLL FR DAT
6. APH
7. INCOMPETENTCX OR UNS
8. UNWELL MOTHER
9. MOTHER FEELINGS

0 40 DT1

1. NVD
2. BREECH
3. FORCEPS
4. LSCS
5. VENTOUSE
6. INDUCD

0 41 DT2

1. NVD
2. BREECH
3. FORCEPS
4. LSCS
5. VENTOUSE
6. INDUCD

0 42 V33

1. UNDER 2 HRS
2. UNDER 8 HRS
3. OVERSHRS

0 43 V34 HUSBAND AT DELVRY

0 44 V35 PUERPER TYPE

1. NORMAL
2. COPLCTD
3. DONT KNW

0 45 CM1

1. PAIN POST EPIDURAL
2. INFECT
3. WARFARN OR THROMBOS

4. RET PLACE
5. PPH
6. ANAEMIA

1SEE SURVEYDATA3

0DOCUMENTATION FOR THE 222 VARIABLES IN THE FILE 'SURVEYDATA'

OREL POS	VARIABLE NAME	VARIABLE LABEL
0 45	CM1	CONT
		7. UNWELL NUM
		8. RET PROD
		9. BABYBLUES
0 46	CM2	
		1. PAIN POST EPIDURAL
		2. INFECT
		3. WARFARN OR THROMBOS
		4. RET PLACE
		5. PPH
		6. ANAEMIA
		7. UNWELL MUM
		8. RET PROD
		9. BABYBLUES
0 47	CM3	
		1. PAIN POST EPIDURAL
		2. INFECT
		3. WARFARN OR THROMBOS
		4. RET PLACE
		5. PPH
		6. ANAEMIA
		7. UNWELL MUM
		8. RET PROD
		9. BABYBLUES
0 48	V37	BABY PROBLMS
0 49	PD1	
		1. LBW
		2. SICK BABY
		3. CONGTL DEFOR
		4. FEEDG PROBLM
		5. JAUNDICE
		6. STCKY EYS OR INFECTN
		7. HYPOTHERM
		8. BRAIN DAM
		9. PREM
0 50	PD2	
		1. LBW
		2. SICK BABY
		3. CONGTL DEFOR
		4. FEEDG PROBLM

1SEE SURVEYDATA3

0DOCUMENTATION FOR THE 222 VARIABLES IN THE FILE 'SURVEYDATA'

OREL POS	VARIABLE NAME	VARIABLE LABEL
0 50	PD2	CONT
		5. JAUNDICE
		6. STCKY EYS OR INFECTN
		7. HYPOTHERM
		8. BRAIN DAM
		9. PREM
0 51	V39	SR FEEDG ATTND

```
0  52   V40        BR FEEDG ESTBD
0  53   V41        HVS OPNION RE PND
0  54   HVR1
                                    1. PREV DEP
                                    2. MARIT ADJ
                                    3. FINAN
                                    4. MOTHR HEALTH
                                    5. MOTHR FEELNGS SELF C
                                    6. TEARFUL OR ANXIETY
                                    7. LIVNG CONDTNS
                                    8. ADJUST DIFF
                                    9. ISOLATD FROM EXTENDN
0  55   HVR2
                                    1. PREV DEP
                                    2. MARIT ADJ
                                    3. FINAN
                                    4. MOTHR HEALTH
                                    5. MOTHR FEELNGS SELF C
                                    6. TEARFUL OR ANXIETY
                                    7. LIVNG CONDTNS
                                    8. ADJUST DIFF
                                    9. ISOLATD FROM EXTENDN
0  56   HVR3
                                    1. PREV DEP
                                    2. MARIT ADJ
                                    3. FINAN
                                    4. MOTHR HEALTH
                                    5. MOTHR FEELNGS SELF C
                                    6. TEARFUL OR ANXIETY
                                    7. LIVNG CONDTNS
                                    8. ADJUST DIFF
                                    9. ISOLATD FROM EXTENDN
1SEE SURVEYDATA5
```

0DOCUMENTATION FOR THE 222 VARIABLES IN THE FILE 'SURVEYDATA'

0REL POS	VARIABLE NAME	VARIABLE LABEL

```
0  56   HVR3       CONT
0  57   HVR4
                                    1. PREV DEP
                                    2. MARIT ADJ
                                    3. FINAN
                                    4. MOTHR HEALTH
                                    5. MOTHR FEELNGS SELF C
                                    6. TEARFUL OR ANXIETY
                                    7. LIVNG CONDTNS
                                    8. ADJUST DIFF
                                    9. ISOLATD FROM EXTENDN
0  58   C1
                                    1. NIL OR WITHDRWL
                                    2. SHEATH
                                    3. CAP
                                    4. PILL
                                    5. IUD
                                    6. STERILIZED
                                    7. VASECT
                                    8. DEPO
0  59   C2
                                    1. NIL OR WITHDRWL
                                    2. SHEATH
                                    3. CAP
```

4. PILL
5. IUD
6. STERILIZED
7. VASECT
8. DEPO

0 60 C3

1. NIL OR WITHDRWL
2. SHEATH
3. CAP
4. PILL
5. IUD
6. STERILIZED
7. VASECT
8. DEPO

0 61 V44 SIX WEEK INTERVIEW DATE

1SEE SURVEYDATA3

0DOCUMENTATION FOR THE 222 VARIABLES IN THE FILE 'SURVEYDATA'

OREL POS	VARIABLE NAME	VARIABLE LABEL
0 62	V45	MOTHR APPET
0 63	V46	ATTMTG LOSE WEIGHT
0 64	V47	LOST WEGHT
0 65	V48	WT LOSS MORE
0 66	V49	QUANTTY WT LOST
0 67	V50	CONSTIPTN
0 68	V51	MOTHERS SPEECH
0 69	V52	CAN SHE SLEEP
0 70	V53	NIGHT WAKING
0 71	V54	EARLY WAKNG
0 72	V55	OTHER SLEEP DIST
0 73	V56	EXPLNS SLEEP PROBLMS

0. NORMAL
1. ANXY
2. SWEATING
3. EXCESSV WT GN
4. LGHT SLEEPR
5. DIFFCLT BABY
6. MOTHR UNWELL

0 74 V57 IS MOTHER FED UP
0 75 V58 IS UNHAPPY
0 76 UNR1

1. BEREAVMNT
2. HUSB AWAY
3. HOUSING
4. EX WT GAIN
5. UNEM OR FINAN
6. LIFE EVENTS
7. UNWELL MOTHR
8. DIFFCLT BABY
9. IRRITABLE

1SEE SURVEYDATA3

0DOCUMENTATION FOR THE 222 VARIABLES IN THE FILE 'SURVEYDATA'

OREL POS	VARIABLE NAME	VARIABLE LABEL
0 76	UNR1	CONT
0 77	UNR2	

1. BEREAVMNT
2. HUSB AWAY

3. HOUSING
4. EX WT GAIN
5. UNEM OR FINAN
6. LIFE EVENTS
7. UNWELL MOTHR
8. DIFFCLT BABY
9. IRRITABLE

0	78	V60	UNHAPY NO REASNS
0	79	V61	CRYNG SPELLS
0	80	V62	LIBIDO CHANGE
0	81	V63	POSITIVE RE SELF
0	82	V64	POSITIVE ATTITUDE
0	83	V65	SELFCRITICISM
0	84	V66	DECSNMAKING
0	85	V67	NEGLECTED APPEARNC
0	86	V68	CHANG HUSBAND ATTACHMT
0	87	V69	LESS ATTACHD
0	88	V70	MORE ATTACHED
0	89	V71	FATHER ASSISTS
0	90	V72	BABY SEPARATION
0	91	BSD1	

1. MOTHR IN HOSPL
2. BABY IN HOSPL
3. BABY WTH EXTD FAMLY
4. SCBU

1SEE SURVEYDATA3

GDOCUMENTATION FOR THE 222 VARIABLES IN THE FILE 'SURVEYDATA'

OREL POS	VARIABLE NAME	VARIABLE LABEL
0 92	BSD2	

1. MOTHR IN HOSPL
2. BABY IN HOSPL
3. BABY WTH EXTD FAMLY
4. SCBU

0 93	V74	BABY WITH MOTHER
0 94	V75	MOTHER FEELS RELATNG WELL BABY
0 95	V76	PROFESION OPINION MOTHER BABY RELATNP
0 96	V77	MOTHER TR YING TO MEET NEEDS BABY
0 97	V78	PROFESSNL OPNN RE MOTHER BA BY NE
0 98	V79	MOTHER FEELS SHE CAN COPE
0 99	V80	PROFESSL OPNN MOTHER COPES
0100	V81	BABYPROBLMS
0101	V82	FEEDNG PROBLEMS
0102	V83	BAB ILLNESS
0103	DRB1	

1. THRUSH
2. STICKY UMB
3. SORE BUTTOCKS OR ECZ
4. STCKY EYS
5. JAUNDICE
6. UNWELL BABY
7. FEEDNG PROBLM
8. LBW
9. CONGENTL

0104	DRB2	

1. THRUSH
2. STICKY UMB
3. SORE BUTTOCKS OR ECZ
4. STCKY EYS
5. JAUNDICE

```
                                        6. UNWELL BABY
                                        7. FEEDNG PROBLM
1SEE SURVEYDATA3

0DOCUMENTATION FOR THE  222 VARIABLES IN THE FILE 'SURVEYDATA'
OREL  VARIABLE  VARIABLE LABEL
 POS      NAME

0104   DRB2        CONT
                                        8. LBW
                                        9. CONGENTL
0105   DRB3
                                        1. THRUSH
                                        2. STICKY UMB
                                        3. SORE BUTTOCKS OR ECZ
                                        4. STCKY EYS
                                        5. JAUNDICE
                                        6. UNWELL BABY
                                        7. FEEDNG PROBLM
                                        8. LBW
                                        9. CONGENTL
0106   V85         MOTHER MEETS PEOPLE
0107   V86         MOT                                HER AVDS PE
0108   V87         EXCESSV DEMNDS ON HUSBAND
0109   V88         EXCESS          DEMANNDS ON FAMILY
0110   V89         EXCESSV DEMANDS ON HV
0111   V90         MOTHER           LOOKS UNHAPPY
0112   V91         MOTHER LOOKS WHEN TALKS
0113   V92         CONFID POST
0114   V93         APPEARANCE AND GROOMING
0115   V94         HAD PND
0116   V95         PND NOW
0117   V96         REF TO GP
0118   V97         MOTHER TAKES DRUGS
0119   DR1
                                        1. ANTIDEPRESS OR TRANQ
                                        2. WARFAR
                                        3. IRON

1SEE SURVEYDATA3

0DOCUMENTATION FOR THE  222 VARIABLES IN THE FILE 'SURVEYDATA'
OREL  VARIABLE  VARIABLE LABEL
 POS      NAME

0119   DR1         CONT
                                        4. ANTIBIO OR FUNG
                                        5. MODURET
                                        6. ANTIHISTAMN
                                        7. INSULIN
0120   DR2
                                        1. ANTIDEPRESS OR TRANQ
                                        2. WARFAR
                                        3. IRON
                                        4. ANTIBIO OR FUNG
                                        5. MODURET
                                        6. ANTIHISTAMN
                                        7. INSULIN
0121   V99         PND IN FUTURE
0122   RFP1
                                        1. PREV PND OR IMMATR M
                                        2. FINANC PROB
                                        3. MARIT PROBLMS
```

4. LIFE EVENTS OR LIV C
5. MOTHR UNWELL
6. HUSB AWAY
7. NO EXTND FAM
8. REJECT OF BABY
9. OVER ANXIETY OR MOO

0123 RFP2

1. PREV PND OR IMMATR M
2. FINANC PROB
3. MARIT PROBLMS
4. LIFE EVENTS OR LIV C
5. MOTHR UNWELL
6. HUSB AWAY
7. NO EXTND FAM
8. REJECT OF BABY
9. OVER ANXIETY OR MOO

0124 RFP3

1. PREV PND OR IMMATR M
2. FINANC PROB
3. MARIT PROBLMS
4. LIFE EVENTS OR LIV C
5. MOTHR UNWELL

1SEE SURVEYDATA3

0DOCUMENTATION FOR THE 222 VARIABLES IN THE FILE 'SURVEYDATA'

OREL POS	VARIABLE NAME	VARIABLE LABEL
0124	RFP3	CONT
		6. HUSB AWAY
		7. NO EXTND FAM
		8. REJECT OF BABY
		9. OVER ANXIETY OR MOO
0125	V101	PINK EDD AT 28WEEKS
0126	V102	DATE QUESTIONN
0127	V103	SCORE
0128	V104	GREEN SCORE
0129	V105	CCEI ANX
0130	V106	PHOBIA
0131	V107	OBS
0132	V108	SOM
0133	V109	DEP
0134	V110	HYS
0135	V111	ORIGINAL HV NO
0136	V112	BABY CODE NO OR GREEN CASE NO
0137	V113	NEW HV SINCE 6 WEEKS
		1. YES
		2. NO
		3. MORE THAN ONE
		4. RET FRM HV INCOMP
		5. HV NEW RET INCOM
		6. HV SICK
		7. QUEST LOST
		8. HV UNTRACEABLE
0138	V114	FAM EX PHD
0139	V115	MOVD ADDRS UNKNWN

1SEE SURVEYDATA3

0DOCUMENTATION FOR THE 222 VARIABLES IN THE FILE 'SURVEYDATA'

OREL POS	VARIABLE NAME	VARIABLE LABEL

```
0140   V116      NEW PHD ADDRSS
0141   V117      HV TOTAL CONTCTS
0142   V118      HOMECONTACTS
0143   V119      CLNC CONTCTS
0144   V120      ANTHR HV TOTL CONTCTS
0145   V121      ANTHR HOMECONTACTS
0146   V122      ANTHR CLINC CONTACTS
0147   V123      MORE HVISITING
0148   V124      MORE REASONS
                                1. UNCONF MTHR
                                2. DEPRESSED
                                3. MARR DIFFICLTS
                                4. SICK BABY OR CHLDN
                                5. AGAROPHOBIC
                                6. EXCESS CLINC ATTE
                                7. STUD HV
                                8. FEDG PROBLM OR     SL
                                9. CONS PROF CONCRN
0149   V125      PND SINCE 6WKS
0150   V126      DATE
0151   V127      HOW LONG
0152   V128      NO DYS WKS OR MNTHS
0153   V129      SLEEP
0154   V130      SLP EXPLNTNS
                                1. MISMAN BABY
                                2. EARLY WAKNG
                                3. ANXY
                                4. DIFFCLTY TO SLP
                                5. POOR SLEEP PATT
```

1SEE SURVEYDATA3

0DOCUMENTATION FOR THE 222 VARIABLES IN THE FILE 'SURVEYDATA'

0REL POS	VARIABLE NAME	VARIABLE LABEL
0155	V131	WT CHANGES
0156	V132	WT EXPLNTNS
		1. WT GAIN EXCESS
		2. WT LOSS EXCESS
0157	V133	MOTH SELF ATTDS
0158	V134	SELF ATTDS EXPLNS
		1. VERY UNSURE
		2. SELF CRITICAL
		3. LACK SELFINTRST
		4. UNABLE TO COPE
		5. LONELY MISS HUSB
		6. SELFPITY
		7. INADEQUACY
0159	V135	MOTH ATTDS BABY
0160	V136	BABY ATTDS EXPLNS
		1. LACKS CONFIDNCE
		2. NEGLCTS BABY
		3. ANX RE HLTH
		4. ANX RE BABY HLTH
		5. HOSTLTY CHLDRN
		6. STRAIND RELSHPS
0161	V137	MOTH ATTDS TO HUSB
0162	V138	HUSB EXPLNTN
		1. ISOLATS FRM HUSB
		2. AGGRESSN
		3. SEX PRBLMS
		4. COMMN PROBLMS

5. HUSB NONUNDERSTD
6. HUSB MISSNG

0163 V139 MOTH ATTDS OTHERS
0164 V140 OTHERS EXPLNTNS

1. CONST RET MGM
2. HANDCPPD CHLD
3. RUDE TO PROFFNLS
4. CRITCL FAMLY
5. INADEQUATEHOUSNG

1SEE SURVEYDATA3

CDOCUMENTATION FOR THE 222 VARIABLES IN THE FILE 'SURVEYDATA'

OREL POS	VARIABLE NAME	VARIABLE LABEL
0164	V140	CONT

6. ANX RE FAMILY
7. ALL RELATSHPS PR
8. DEP ON PROFF

0165 V141 OTHR REASNS
0166 V142 OTHR EXPLNTS

1. MISMAN STP CHLDN
2. EXCESS TEARS
3. GEN NEGLECT
4. GEN NEGLCT
5. EXCESS TME MGM
6. ABN BEHAVR

0167 V143 MOTH SEEN OTHR H AND SS PERSONNEL
0168 V144
0169 V145 GROUP ATTDCE
0170 V146 WHICH GROUPS

0. NONE
1. NEW MTHRS
2. CHURCH
3. NCBT
4. MAMA
5. MOTH AND TODD
6. COFF WTH FRNDS
7. STEPSOR CHGU
8. PN SUPP GRP
9. OTHER

0171 V147 WHN LAST SEEN
0172 V148 OTHR HV COMMNTS

1. MAR PROBLMS
2. LIBIDO DOWN
3. EXCESS ANX OR PRG
4. REQ XTRA PROF SP
5. CONS PROF CONCRN
6. HUSB LFT WTHDRWN
7. MTHR UNCOOP SHY
8. SICK BABY
9. HVD LTTL CNTC

1SEE SURVEYDATA3

CDOCUMENTATION FOR THE 222 VARIABLES IN THE FILE 'SURVEYDATA'

OREL POS	VARIABLE NAME	VARIABLE LABEL
0172	V148	CONT
0173	V149	SNT TO MTHR
0174	V150	RETND BY MTHR

0. SENT AND RET

1. OUT PHD
2. ANX
3. HV CANT IDENTFY
4. HV DID NOT COMPLT
5. HV REQ NO FOLLUP
6. SENT AND NOT RET

0175 V151 BABY WT
0176 V152 ATTDCE MTH GROUPS
0177 V153 WHICH GROUPS

0. NONE
1. NEW MTHRS
2. CHURCH
3. NCBT
4. MAMA
5. MOTH AND TODD
6. COFF WTH FRNDS
7. STEPS
8. PN SUPP GRP
9. CHLD GUID

0178 CRBP1

1. MGM
2. OTH GRANDPRNT
3. HUSBAND
4. DOCTOR
5. HV
6. OTHR FAM
7. NEIGHBRS
8. OTHRS
9. NOONE

0179 CRBP2

1. MGM
2. OTH GRANDPRNT
3. HUSBAND
4. DOCTOR

1SEE SURVEYDATA3

0DOCUMENTATION FOR THE 222 VARIABLES IN THE FILE 'SURVEYDATA'

OREL POS	VARIABLE NAME	VARIABLE LABEL

0179 CRBP2 CONT

5. HV
6. OTHR FAM
7. NEIGHBRS
8. OTHRS
9. NOONE

0180 CRBP3

1. MGM
2. OTH GRANDPRNT
3. HUSBAND
4. DOCTOR
5. HV
6. OTHR FAM
7. NEIGHBRS
8. OTHRS
9. NOONE

0181 V155 MORE ANX OR DEP PERIOD
0182 V156 DATE WHEN DEP
0183 V157 HOW LONG DEP
MISS

0. NOT COMPLT
1. FEW DAYS
2. FEW WEEKS

3. LONGER
4. MR THN A YEAR
5. INFREQ DAYS THRU

0184 V158 SLEE
0185 V159 WEIGHT
0186 V160 TIREDNESS
0187 V161 TEARS
0188 V162 IRRITABLE
0189 V163 ABNOR FEELNGS
0190 V164 OTHR SYMPT

1. ABN ANX
2. ILL OR INFECT

1SEE SURVEYDATA3

0DOCUMENTATION FOR THE 222 VARIABLES IN THE FILE 'SURVEYDATA'

OREL POS	VARIABLE NAME	VARIABLE LABEL
0190	V164	CONT

3. UNABL TO COPE
4. AGGRESS
5. IRRAT BEH TO CHL
6. INAD FEELGS
7. LIBIDO DOWN
8. FLS ISOL AGOROPPH
9. MTHR SUBMRG PR

0191 CRSP1

0. NOONE
1. MGM
2. OTHR GRNDPTS
3. HUSB OR CO
4. DOCTR
5. HV
6. OTHR FAM
7. NEIGHBRS
8. OTHRS
9. NOT NECESS

0192 CRSP2

0. NOONE
1. MGM
2. OTHR GRNDPTS
3. HUSB OR CO
4. DOCTR
5. HV
6. OTHR FAM
7. NEIGHBRS
8. OTHRS
9. NOT NECESS

0193 V166 WHERE CONTCT LIVES
MISS

0. NOT APPLI
1. LESS 5 MILES
2. MORE 5 MILS
3. MORE THAN 50

0194 V167 OWN MOTHER ALIVE
0195 V168 WHRE OWN MOTHR LIVES
MISS

0. NOT APPLIC
1. LESS THAN 5
2. MORE THAN 5

1SEE SURVEYDATA3

0DOCUMENTATION FOR THE 222 VARIABLES IN THE FILE 'SURVEYDATA'

OREL	VARIABLE	VARIABLE LABEL

POS	NAME	
0195	V168	CONT
		3. MORE THAN 50
0196	V169	OWN MOTHR HAS TELPHN
0197	V170	UPBRIGNG SIMLR TO OWN
0198	V171	EXPLNT RE UPBRING
		1. VRY STRCT
		2. LITTL TIM FR CHL
		3. OVERMOTHERED
		4. REASNS UNCLEAR
		5. BRIBRY
		6. IMMORAL
		7. TOO DIFF TOANS
		8. MAT CHANG BEF 11
		9. UNH PAR BRKN
0199	V172	BABY FATHER CHANGED
0200	V173	FATHER CHANGE EXPLNTN
		0. POS REAS
		1. HUSB TO BJS BRD
		2. COMP DISINTRST
		3. LEFT
		4. IRRIT WTH CHLDN
		5. NOT MARR BA FAT
		6. DIV
		7. DEPR NO UNDERST
		8. LIBIDO DOWN
0201	V174	SNT TO GP
0202	V175	GP RETND
		0. NO
		1. YES
		2. HV DIDNT ASK GP
		3. GP REF
		4. FAM MVD
		5. NOT SENT REAS UNK
		6. MTHR RET LATE
0203	V176	HAS CONSLTD

1SEE SURVEYDATA

DOCUMENTATION FOR THE 222 VARIABLES IN THE FILE 'SURVEYDATA'

OREL POS	VARIABLE NAME	VARIABLE LABEL
0204	V177	HAD PND
0205	V178	DATE OF PND
0206	V179	SYMPTMS NO
0207	V180	
0208	V181	MEDCTN
0209	V182	REFR PSYCHTRST
0210	V183	1 YR CCEI ANX
0211	V184	PHO
0212	V185	OBS
0213	V186	SOM
0214	V187	DEP
0215	V188	HYS
0216	IFSEC	
		1. YES
		2. NO
0217	V189	
0218	V190	
0219	LONG	
0220	DEP	

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0221  SOCLASS
0222  MOTHER
1SEE SURVEYDATA3

 FILE   SURVEYDA (CREATION DATE = 10/03/86)
0CPU TIME REQUIRED..     3.24 SECONDS


                    5 FINISH

0          NORMAL END OF JOB.
               5 CONTROL CARDS WERE PROCESSED.
               0 ERRORS WERE DETECTED.

END OF LISTING OF FILE :SSI005.FILEINFO(3,*,1) FOR USER :SSI005 AT 198

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PSS BATCH SYSTEM                                                    24/06/82        PAGE    1

PSS FOR ICL 2900, VERSION 4.2(IBM RELEASE 8.1) FEBRUARY 1981

                        CURRENT DOCUMENTATION FOR THE SPSS BATCH SYSTEM

DER FROM MCGRAW-HILL:  SPSS, 2ND ED. (PRINCIPAL TEXT)      ORDER FROM SPSS INC.:  SPSS STATISTICAL ALGORITHMS
                       SPSS PRIMER (BRIEF INTRO TO SPSS)                       SPSS POCKET GUIDE, RELEASE 8
                       SPSS UPDATE (USE W/SPSS,2ND FOR REL. 7 & 8)             KEYWORDS: THE SPSS INC. NEWSLET

FAULT SPACE ALLOCATION..      ALLOWS FOR..     55 TRANSFORMATIONS
RKSPACE     38500 BYTES                       220 RECODE VALUES + LAG VARIABLES
ANSPACE      5500 BYTES                       880 IF/COMPUTE OPERATIONS

          1 GET FILE      SURVEYDATA

ECTED FILE SURVEYDA FOUND FILE NONAME


                    FILE NONAME   HAS 216 VARIABLES

                    THE SUBFILES ARE..

                                  NO OF
                    NAME          CASES

                    WHITE           225
                    GREEN            77
                    YELLOW           84


 TIME REQUIRED..    0.54 SECONDS


          2 *SELECT IF     (V155 EQ 1)
          3 *SELECT IF     (V157 GT 1)
          4 FREQUENCIES    INTEGER=V157(2,5) V158 V159 V160 V161 V162 V163(1,2)
          5                V164(1,9) V166 V167(0,3) V168 V169 V170(1,3) V179(1,9)
          6                V172 V173(0,8)
          7 STATISTICS     1,2

EQUENCIES* PROBLEM REQUIRES     460 BYTES OF SPACE
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V157 HOW LONG DEP

CATEGORY LABEL	CODE	ABSOLUTE FREQUENCY	RELATIVE FREQUENCY (PERCENT)	ADJUSTED FREQUENCY (PERCENT)	CUMULATIVE ADJ FREQ (PERCENT)
FEW WEEKS	2	47	42.7	42.7	42.7
LONGER	3	41	37.3	37.3	80.0
MR THN A YEAR	4	7	6.4	6.4	86.4
INFREQ DAYS THRU	5	15	13.6	13.6	100.0
	TOTAL	110	100.0	100.0	

MEAN 2.709 STD ERR 0.097

VALID CASES 110 MISSING CASES 0

SPSS BATCH SYSTEM

FILE NONAME (CREATION DATE = 12/02/82)
SUBFILE WHITE GREEN YELLOW

V158 SEEE

CATEGORY LABEL	CODE	ABSOLUTE FREQUENCY	RELATIVE FREQUENCY (PERCENT)	ADJUSTED FREQUENCY (PERCENT)	CUMULATIVE ADJ FREQ (PERCENT)
	1	44	40.0	40.4	40.4
	2	65	59.1	59.6	100.0
OUT OF RANGE		1	0.9	MISSING	100.0
	TOTAL	110	100.0	100.0	

MEAN 1.596 STD ERR 0.047

VALID CASES 109 MISSING CASES 1

SPSS BATCH SYSTEM

FILE NONAME (CREATION DATE = 12/02/82)
SUBFILE WHITE GREEN YELLOW

V159 WEIGHT

CATEGORY LABEL	CODE	ABSOLUTE FREQUENCY	RELATIVE FREQUENCY (PERCENT)	ADJUSTED FREQUENCY (PERCENT)	CUMULATIVE ADJ FREQ (PERCENT)
	1	33	30.0	30.3	30.8
	2	74	67.3	69.2	100.0
OUT OF RANGE		3	2.7	MISSING	100.0
	TOTAL	110	100.0	100.0	

MEAN 1.692 STD ERR 0.045

VALID CASES 107 MISSING CASES 3

SPSS BATCH SYSTEM

FILE NONAME (CREATION DATE = 12/02/82)
SUBFILE WHITE GREEN YELLOW

V160 TIREDNESS

CATEGORY LABEL	CODE	ABSOLUTE FREQUENCY	RELATIVE FREQUENCY (PERCENT)	ADJUSTED FREQUENCY (PERCENT)	CUMULATIVE ADJ FREQ (PERCENT)
	1	81	73.6	73.6	73.6
	2	29	26.4	26.4	100.0
	TOTAL	110	100.0	100.0	

MEAN 1.264 STD ERR 0.042

VALID CASES 110 MISSING CASES 0

SPSS BATCH SYSTEM

FILE NONAME (CREATION DATE = 11/02/82)
SUBFILE WHITE GREEN YELLOW

V161 TEARS

CATEGORY LABEL	CODE	ABSOLUTE FREQUENCY	RELATIVE FREQUENCY (PERCENT)	ADJUSTED FREQUENCY (PERCENT)	CUMULATIVE ADJ FREQ (PERCENT)
	1	73	66.4	67.6	67.6
	2	35	31.8	32.4	100.0
OUT OF RANGE		2	1.8	MISSING	100.0
	TOTAL	110	100.0	100.0	

MEAN 1.324 STD ERR 0.045

VALID CASES 108 MISSING CASES 2

SPSS BATCH SYSTEM

FILE NONAME (CREATION DATE = 11/02/82)
SUBFILE WHITE GREEN YELLOW

V162 IRRITABLE

CATEGORY LABEL	CODE	ABSOLUTE FREQUENCY	RELATIVE FREQUENCY (PERCENT)	ADJUSTED FREQUENCY (PERCENT)	CUMULATIVE ADJ FREQ (PERCENT)
	1	77	70.0	72.0	72.0
	2	30	27.3	28.0	100.0
OUT OF RANGE		3	2.7	MISSING	100.0
	TOTAL	110	100.0	100.0	

MEAN 1.280 STD ERR 0.044

VALID CASES 107 MISSING CASES 3

SPSS BATCH SYSTEM

FILE NONAME (CREATION DATE = 17/02/82)
SUBFILE WHITE GREEN YELLOW

V163 ABNOR FEELNGS

CATEGORY LABEL	CODE	ABSOLUTE FREQUENCY	RELATIVE FREQUENCY (PERCENT)	ADJUSTED FREQUENCY (PERCENT)	CUMULATIVE ADJ FREQ (PERCENT)
	1	60	54.5	58.3	58.3
	2	43	39.1	41.7	100.0
OUT OF RANGE		7	6.4	MISSING	100.0
	TOTAL	110	100.0	100.0	

MEAN 1.417 STD ERR 0.049

VALID CASES 103 MISSING CASES 7

SPSS BATCH SYSTEM

FILE NONAME (CREATION DATE = 17/02/82)
SUBFILE WHITE GREEN YELLOW

V164 OTHR SYMPT

CATEGORY LABEL	CODE	ABSOLUTE FREQUENCY	RELATIVE FREQUENCY (PERCENT)	ADJUSTED FREQUENCY (PERCENT)	CUMULATIVE ADJ FREQ (PERCENT)
BN ANX	1	12	10.9	20.0	20.0
LL OR INFECT	2	15	13.6	25.0	45.0
NABL TO COPE	3	10	9.1	16.7	61.7
GGRESS	4	4	3.6	6.7	68.3
RRAT BEH TO CHL	5	2	1.8	3.3	71.7
VAD FEELGS	6	2	1.8	3.3	75.0
IBIDO DOWN	7	5	4.5	8.3	83.3
.S ISOL AGOROPPH	8	7	6.4	11.7	95.0
THR SUBMRG PR	9	3	2.7	5.0	100.0
T OF RANGE		50	45.5	MISSING	100.0
	TOTAL	110	100.0	100.0	

AN 3.800 STD ERR 0.343

LID CASES 60 MISSING CASES 50