Midwifery 29 (2013) 779–786

Contents lists available at SciVerse ScienceDirect

Midwifery

journal homepage: www.elsevier.com/midw

Illness perceptions in mothers with postpartum depression

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ARTICLE INFO

Article history:
Received 23 February 2012
Received in revised form
27 June 2012
Accepted 29 June 2012

Keywords:
Illness perceptions
Postnatal depression
Questionnaires

ABSTRACT

Objective: to examine perceptions of mothers experiencing postpartum depression utilising the revised Illness Perception Questionnaire (IPQ-R), to explore relationships between illness perceptions, depression severity and perceptions of maternal bonding, and to assess the psychometric properties within this population.
Design: longitudinal correlational design.
Setting: North West of England, UK.
Participants: 43 mothers, who screened positive for postpartum depression (mean age 29.36 years) with babies whose mean age was 4 months.
Methods: participants were recruited through health services. Participants completed the IPQ-R and measures of depression severity and maternal bonding. Illness perceptions and depression severity were assessed at 2 time points, 4 weeks apart.
Findings: mothers endorsed IPQ-R subscales of cyclical timeline, consequences, emotional representations, treatment and personal control. IPQ-R subscale scores and depression severity correlated significantly at Time 1. Initial IPQ-R subscale scores, however, were not associated with and accounted for little variation in depression severity at Time 2. IPQ-R identity and consequence subscales positively correlated with perceived bonding difficulties.
Key conclusions and clinical implications: the IPQ-R was shown to be a reliable measure of illness perceptions in mothers experiencing postpartum depression. The maternal illness perceptions endorsed in this study have implications for clinical practice. Interventions aimed at developing a more coherent understanding of depression may enhance beliefs of personal control over symptoms, reduce the number of perceived symptoms and associated emotional distress. Educating mothers regarding the benefits of interventions may be important in increasing the number of mothers accessing support for postpartum depression.

Introduction

One of the most widely used theoretical models to explore how individuals perceive their physical health problems is the Self-Regulation Model (SRM) developed by Howard Leventhal. The SRM proposes that a causal relationship exists between illness beliefs and health outcomes, which is mediated by coping behaviours (Leventhal et al., 1984; Hampson et al., 1990, 1995).

The SRM also proposes that illness perceptions are represented as five main dimensions (Leventhal and Diefenbach, 1991) (1) *causal*—beliefs about the cause(s) of the illness, (2) *identity*—beliefs concerning the illness' label and symptoms, (3) *timeline*—perceptions about the time course of an illness, characterised along the *acute–chronic* dimension where individuals may perceive their illness as chronic or acute, or cyclical in nature (where the condition appears under a particular set of circumstances, such as after stressful life events), (4) *cure–control*—beliefs about how the condition is treated and effectiveness of available treatment and (5) *consequences*—perceived effect(s) of the illness on an individual's life.

The Illness Perception Questionnaire (IPQ) (Weinman et al., 1996) was developed as a measure of the SRM dimensions. It was later revised (IPQ-R) (Moss-Morris et al., 2002) to include an assessment of *emotional representation* (one's emotional response to the illness) and *illness coherence* (the sense of having a

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http://dx.doi.org/10.1016/j.midw.2012.06.020

comprehensive understanding of the illness). In addition, the *timeline scale* was separated into *acute–chronic* and *cyclical* and the *control* scale into *personal control* and *treatment control*. The IPQ and IPQ-R have been used extensively in physical health and have been shown to be valid and reliable measures of illness beliefs (Moss-Morris et al., 2002).

Within the last decade research has applied the SRM to explore illness perceptions in mental health. For example, the IPQ has been used with depressed participants: firstly in primary care patients (Brown et al., 2001), then in an all-female sample with a history of depression approximately half of whom were still actively depressed (Fortune et al., 2004) and more recently in a sample of women experiencing antenatal depression who were followed up over time to assess treatment use (O'Mahen et al., 2009).

Across these three studies, individuals perceived their depression as having many symptoms and negative consequences, being cyclical in nature and amenable to control/cure. Commonly attributed causes of depression included; stress, own behaviour, hereditary, relationship and physical health difficulties. Women experiencing depression within the perinatal period endorsed medical illness causes, attributing their depression to their own state of mind and pregnancy-related changes, such as hormones, lack of sleep and difficulties in adjusting to being pregnant (O'Mahen et al., 2009).

In terms of correlations between illness dimensions, Fortune et al. (2004) noted that women who endorsed more depressive symptoms perceived their depression as chronic, with many negative consequences. Women who perceived their depression as chronic were also less likely to believe depression was controllable and viewed it as having more personal consequences.

Overall, the IPQ was found to be a reliable measure of illness perceptions for depression and discriminated between women actively depressed and those who were not. However, during interviews with participants, a number of the causal subscale items were deemed non-applicable to depression (Fortune et al., 2004).

In terms of outcomes, perceptions of depression were significantly associated with current and past treatment-seeking behaviour, medication adherence and coping strategies. Beliefs regarding the cause, seriousness and response to medication had the greatest influence on treatment use and medication adherence (Brown et al., 2001). In addition, perceived illness chronicity influenced treatment-seeking (O'Mahen et al., 2009). However, as the original version of the IPQ was used in these three studies, illness representations and coherence were not explored. As cross-sectional designs were used, the direction of relationships between illness perceptions, illness severity, coping and treatment-seeking behaviour could not be determined (Brown et al., 2001; Fortune et al., 2004).

Despite some exploration of depression-related perceptions, there has been little research examining illness beliefs of mothers experiencing depression after the birth of a child and the impact of these beliefs on bonding.

Postpartum depression (PPD) affects 10–15% of mothers (O'Hare and Swain, 1996). There is evidence suggesting the nature of symptoms differs little between depression within the postnatal period and depression experienced at any other time within the life cycle (Whiffen and Gotlib, 1993). However, studies highlight that mothers experiencing PPD report a greater frequency of aggressive thoughts towards their baby than depressed mothers with non-postpartum onset (Wisner et al., 1999).

Crucially, PPD has been associated with negative outcomes for children whose mothers experience this depression, including poorer cognitive and emotional development, poor attachment and behavioural problems (Murray et al., 1996). Even mild depressive symptoms can have a significant impact on maternal bonding (Moehler et al., 2006). PPD can also be the first episode in a life-long pattern of recurrent depression (Boyce and Stubbs, 1994) and is associated with an increased usage of health services (Dennis, 2004) alongside significant cost expenditure for health services (Civic and Holt, 2000). Therefore, effective treatment and adequate support for mothers with depression after childbirth are paramount. Clinical guidelines (National Institute of Clinical Excellence, 2007) recommend that, depending on severity, women experiencing depression during the postnatal period should be offered access to guided self-help and other forms of effective talking therapies. However, some mothers with PPD are reluctant to seek professional help for fear they will be admitted to a psychiatric unit, get 'locked up' or have their baby taken away from them (Hall, 2006). In a qualitative study conducted by McIntosh (1993), less than half of the depressed mothers interviewed (18 out of 38) sought assistance: Health-care professionals were regarded either as threatening or as an inappropriate solution to the problem.

To enable appropriate opportunities for mothers to disclose their feelings and seek support from services, it is essential that health-care professionals have an understanding of how mothers perceive their depression during this time. Identifying illness perceptions in mothers with PPD may help to refine treatment and determine whether aspects of illness perception are predictive of depression severity.

Using the IPQ-R, this preliminary study examined illness perceptions of mothers experiencing PPD. The aims of the study were to examine (1) perceptions of mothers experiencing postpartum depression utilising the revised Illness Perception Questionnaire (IPQ-R), (2) to explore relationships between illness perceptions, depression severity and perceptions of maternal bonding, and (3) to assess the psychometric properties within this population.

Methods

Design

A longitudinal correlational questionnaire design was used to explore illness perceptions and the psychometric properties of the IPQ-R.

Measures

The Illness Perceptions Questionnaire revised (IPQ-R)

The IPQ-R, modified for PPD, was used to measure illness perceptions across the SRM dimensions: identity, cause, timeline (acute–chronic and cyclical), illness coherence, consequences, cure–control (personal and treatment control) and emotional representations. As the authors recommend modifications, 2 subscales were revised. The identity subscale was revised to include the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (American Psychiatric Association (APA), 1994) criteria for major depressive disorder, namely: 'depressed mood', 'loss of interest and/or pleasure in activities', 'weight loss/gain (without dieting)', 'feelings of restlessness', 'feelings of worthlessness', 'difficulty concentrating', 'fatigue/loss of energy', 'sleep difficulties' 'recurrent thoughts about death' and 'thoughts of suicide or self-harm'. The remaining items of the identity subscale were 'fluctuations in mood', 'over preoccupation with baby's well-being and complete disinterest in baby'. Participants were asked whether they had experienced each symptom since their depression (*yes*/*no*) and whether they believed it was related to their depression and/or to being a mother with a young child. *Yes* responses on symptoms attributed to depression were given a