JOGNN

RESEARCH

Enablers and Barriers to Seeking Help for a Postpartum Mood Disorder

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Keywords
postpartum mood disorders
help-seeking behaviors
barriers
enablers

ABSTRACT

Objective: To explore the barriers and enablers identified by women experiencing a postpartum mood disorder (PPMD) that preclude and facilitate their help-seeking behaviors for this often devastating illness.

Design: A qualitative study using a grounded theory approach.

Setting: Well-Baby Clinics offered through the Public Health Department, Early Years Centres, Mothercraft, and a Parent Resource Centre in a large Canadian city.

Participants: Ten women who had either been formally diagnosed as having a PPMD or who self-identified as experiencing a constellation of symptoms indicative of a PPMD.

Methods: Interviews that were transcribed verbatim and analyzed using a grounded theory approach as described by Strauss and Corbin.

Results: The core category of "having postpartum" captured the essence of women's experiences in seeking help for a PPMD. Women identified four main stressors that contributed to their development of a PPMD, two barrier categories, and an enabler category that influenced their help-seeking behaviors. Through navigation of formal and informal help, women were able to begin to reclaim the mothering instincts they had lost to mental illness.

Conclusions: Pregnancy, birth, and becoming a mother collectively represent a critical period of physical and emotional upheaval in a woman's life. The need for a holistic care approach that supports the emotional and physical health of the dyad is imperative.

JOGNN, 40, 450-457; 2011. DOI: 10.1111/j.1552-6909.2011.01264.x

Accepted April 2011

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The author reports no conflict of interest or relevant financial relationships.

The development of maternal mood disturbances in the postpartum period is not a newly emergent phenomenon but rather has been noted as early as the 5th century BC in the works of Hippocrates (Ugarriza, 2002). In current times, several distinct mood and anxiety disorders have been identified during the postnatal period each with unique presentations and symptoms including maternal "blues," postpartum depression (PPD), postpartum psychosis, postpartum anxiety disorders, bipolar disorders, and post-traumatic stress disorder (PTSD) secondary to birth trauma (Beck & Driscoll, 2006).

Although women may experience a broad range of psychiatric symptoms following birth and while mothering, maternal "blues," PPD, and postpartum psychosis collectively fall under the umbrella term of postpartum mood disorders (PPMDs) (Beck & Driscoll, 2006), although it should be understood that they are distinct disorders requiring different intervention and support. The focus of this study is women's experiences with seeking help for a mood disturbance (PPMD) that may have developed after giving birth. Where appropriate, the term *PPD* has been substituted for *PPMD* to accurately reflect the terminology used in the literature reviewed. PTSD secondary to birth trauma will also be considered given its relevance to the findings of this study.

The incidence rate for PPD varies anywhere between 10% and 40% worldwide (Holopainen, 2002). More commonly, however, it is estimated that approximately 10% to 15% of new mothers experience a mood disorder that is the most frequently occurring illness experienced by women in the puerperium (Barr, 2006; Pearson, Cooper, Penton-Voak, Lightman, & Evans, 2010). Diagnosis for a PPD is currently subsumed under the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* (*DSM-IV-TR*) criteria for major depression with a modifier that specifies symptoms must begin within 4 weeks of delivery (American Psychiatric Association, 2000). In practice, however, it is generally accepted that PPD may

develop any time in the first year after giving birth (Goodman, 2004).

Women may also experience PTSD secondary to birth trauma, which presents with a unique configuration of symptoms that may include extreme fear, panic, dissociation, and flashbacks (Beck & Driscoll, 2006). Within the literature, it is estimated that between 1.5% and 6% of mothers experience PTSD after childbirth (Beck, 2004). PTSD after childbirth does not have a distinct diagnostic category in the *DSM-IV-TR*, but the experience can be defined as a traumatic event resulting in PTSD that may manifest itself as profound anxiety, depression, hopelessness, fear, and constant arousal deeply affecting a woman's mental health. Because of the affective elements of the disorder, it does share some commonalities with PPMDs.

For women experiencing a PPMD, symptoms may persist for months and even years if left untreated with an increased incidence of self-medication for relief of the debilitating symptoms that define these disorders (e.g., alcohol abuse; Beck & Driscoll, 2006). This single psychiatric event may also be the launch of continuing and recurrent mental illness over the long term and significantly reduces a woman's functioning capacity and her overall quality of life (Forman, Videbech, Hedegaard, Salvig, & Secher, 2000). Women who experience a PPMD also have a 50% higher risk of developing it again in subsequent pregnancies (Gold, 2002; The Maternity Center Association, 2002).

For the infant, short-term and long-term sequelae from exposure to maternal mood disturbances may result in increased risk for neglect, higher accident and hospitalization rates, increased incidence of nonorganic failure to thrive, social and affective disorders, and cognitive delays (Field, 2010; Gao, Paterson, Abbott, Carter, & Iusitini, 2007; Tough et al., 2008). Mothers with mood disturbances often present with a flat affect and show less contingency responsiveness toward their infants (Beck & Driscoll, 2006). Over time, infants of these mentally ill mothers develop an interaction style that "mimics" that of their mothers (Cohen & Nonacs, 2005). By 12 to 18 months of age, cognitive delays, particularly for male children, are often apparent (Tronick, 2007).

Longitudinal studies have evaluated the emotional, cognitive, and behavioral effects of exposure to maternal mood disturbances and have indicated that the effects are enduring. By age 11, male and female children present with lower IQ scores, attention problems, conduct disorders, and difficulties in mathematical reasoning (Hay et al., 2001). For the family as a whole, a PPMD can exert significant influence on the dynamics within the unit and ultimately may result in increased marital discord further disabling the functioning, development, and quality of life for all family members (Beck, 1999; Meighan, Davis, Thomas, & Droppleman, 1999). Therefore, PPMDs represent a complex and multifaceted class of illnesses that may result in serious implications for new mothers and those around them (Gold, 2002).

Postpartum mood disorders represent a complex class of illnesses that may result in serious implications for new mothers and those around them.

Because the presence of a PPMD can have such a significantly negative impact on health, a qualitative study was proposed that asked the central question: What are the perceived barriers and enablers identified by women that preclude and facilitate their seeking help for a postpartum mood disorder? This broad and open-ended research question directed the research process and served as the focus around which all data were collected and analyzed to ultimately allow a better understanding of the enablers and barriers for women to seeking help for a PPMD given the deleterious consequences on women, children, and families.

Method

At present, an understanding of help-seeking behaviors in women experiencing a PPMD remains largely undeveloped. Grounded theory is a recommended method of inquiry for areas in which little previous research has been done on the phenomena of interest (Strauss & Corbin, 1998). The use of a grounded theory approach is also compatible with nursing's goals of generating nursing knowledge, promoting theory development, and informing practice (McCreaddie & Payne, 2010; Meleis, 2005). Therefore, the use of grounded theory as a means of increasing knowledge of the perceived barriers and enablers that direct women's help-seeking behaviors is congruent with the purpose and objectives of this study.

Data Collection

Following ethics approval, posters and flyers were distributed to several Well-Baby Clinics offered through the Public Health Department (PHD), two Ontario Early Year's Centres, Mothercraft, and a Parent Resource Centre where a Postpartum