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First-time parents' shared representation of postpartum depressive symptoms: A qualitative analysis☆

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ABSTRACT

Rationale: Maternal postpartum depression (PD) is a common, debilitating mental health problem. Yet despite effective treatments and widespread screening, treatment rates remain low. Previous studies suggest fathers are frequently consulted about maternal PD symptoms, but little is known about the process, content, or outcomes of these consultations.
Objective: The aim of this work was to explore how couples communicate about PD symptoms. Methods: A single purposive sample of first-time parents stratified by maternal depression screening scores (Edinburgh Postnatal Depression Scale; EPDS) and partner status was drawn from a prospective survey of 300 parents in the U.S. Midwest. Partnered mothers with an elevated (EPDS≥10) depression screening score at one of four time points in the postpartum year comprised the majority of the sample. Smaller samples of participants with low EPDS scores and single participants were included to provide contrast in the consultation and decision making process. A total of 39 participants (22 married/EPDS-high, 10 married/EPDS-low, 5 single/ EPDS-high, 2 single/EPDS-low) were interviewed at one year postpartum. Mothers and fathers were interviewed separately to promote candid responses and allow comparison of illness conceptualizations. Interviews were transcribed, analyzed, and coded through an iterative process.
Results: Couples' conversations about mood changes centered on two overarching questions: *How bad is it?* and *What should we do about it?* Answering *How bad is it?* involved parents comparing maternal mood changes to uncertain depression criteria, and mothers asking partners and female relatives whether changes were normal. Answering *What should we do about it?* had three themes: Fathers feeling unprepared to respond to depression, mothers and fathers expressing reluctance to seek treatment, and couples working collaboratively to accommodate treatment or self-care.
Conclusion: Themes suggest partners significantly contribute to women's conceptualization of mood changes and should be actively engaged in education, screening, and referral practices.

Postpartum depression (PD) is a common and debilitating complication of childbirth, with prevalence rates ranging from 7 to 19% (Banti et al., 2011; Gaynes et al., 2005). Left untreated, PD is associated with poorer maternal and infant health, including impaired mother-child interactions and compromised caretaking behaviors (O'Hara and McCabe, 2013). However, despite increased prenatal depression screening and referral (Milgrom and Gemmill, 2014), approximately two-thirds of individuals experiencing PD go untreated (Rowan et al., 2012). Low treatment rates despite widespread screening and high public health cost suggest a need for fuller understanding of how women evaluate, conceptualize, and respond to postpartum mood changes.

For married or partnered mothers, fathers are common first consultants in PD treatment decisions, according to mothers' survey and interview reports (Henshaw et al., 2013; Montgomery et al., 2009; Woolhouse et al., 2009). Yet, little is known about how mothers and fathers communicate about mood changes, or how such conversations impact women's mental health decision making. Gaining a deeper understanding of how couples communicate

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about PD symptoms is an important step in addressing barriers to PD treatment.

The possible role of partner consultation in PD decision making can be viewed through several health behavior models, from rational choice to social network approaches. Three prominent health behavior models are discussed here: the Health Belief Model (Rosenstock et al., 1988), Theory of Planned Behavior (Ajzen, 1991), and Network Episode Model (Perry and Pescosolido, 2015). Though differences in the assumptions, time frame, and definition of help seeking exist across these models, partner influence can be conceptualized within each.

The Health Belief Model suggests that PD treatment seeking is determined by maternal beliefs that symptoms represent a significant health concern for which the benefits of treatment outweigh the risk or cost. A partner may influence a mother's beliefs about severity or benefit through a "cue to action," such as bringing attention to the symptoms, sharing concerns about severity, or identifying treatment benefits. In a recent survey, mothers with elevated PD symptoms reported that of all close relationships, partners were the most likely to express concern about symptoms (Henshaw et al., 2013). Similarly, the Theory of Planned Behavior suggests that mothers would be more likely to seek treatment if they perceived that the partner viewed treatment positively. In this way, the father's acceptance of treatment, expressed directly or indirectly, would make treatment more acceptable to the mother experiencing symptoms.

In contrast, the Network Episode Model suggests that when confronted with a health problem, individuals habitually activate social network ties to manage their uncertainty about how to proceed (Perry and Pescosolido, 2015). The quality of response from an intimate partner as a key member of the social network would play an ongoing role in shaping the patient's illness career and recovery process.

Within the theoretical frameworks presented, it is not the act of consulting with a partner, per se, but the *content and process* of the consultation, that is thought to influence a move toward or away from treatment. Within the PD treatment seeking literature, prospective survey methods consistently find that most women with PD symptoms consult a partner or other, but only a minority of those who engage in these social consults engage in formal mental health treatment (Henshaw et al., 2013; O'Mahen and Flynn, 2008; Whitton et al., 1996). The reason for this gap between informal social support consultation and treatment seeking is unknown, but may be a result of differences in the consultant's perspective on treatment. Family conversations about treatment reported by patients seeking depression treatment in primary care commonly resulted in patients feeling labeled, judged, lectured to, and rejected (Fernandez Y-Garcia et al., 2012). Among women experiencing PD, fear of stigma and embarrassment are commonly reported reasons for avoiding treatment (Dennis and Chung-Lee, 2006; Goodman, 2009; Woolhouse et al., 2009). Alternately, social supports can directly or indirectly encourage treatment with pro-treatment messages. For example, a large student counseling survey found that roughly 75% of college students who sought counseling had someone recommend help seeking, compared to 18% of those who had not sought help. Further, in the same study, individuals who knew someone else who had sought counseling held more positive beliefs about treatment benefits (Vogel et al., 2007).

It is also suggested that close relationships may influence women's treatment seeking indirectly by altering their conceptualization of *symptoms* (as severe, treatable, or lasting). Consistent with the socio-cognitive models of health behavior described previously, investigations of PD help seeking suggest that a woman's conceptualization of symptoms is related to her likelihood of seeking treatment. Beliefs that symptoms would last a long time predicted treatment use among a sample of pregnant and postpartum women with depressive symptoms (O'Mahen et al., 2009), and alternately, beliefs that symptoms will be temporary have been associated with lack of treatment (Woolhouse et al., 2009). A large prospective study of pregnant women with PD symptoms found that believing a problem was manageable without help was a top reason for not seeking treatment (Goodman, 2009).

Though the importance of an intimate partner in health decision-making is acknowledged in health behavior models, investigations of partner influence have typically been limited to mothers' self-reports. One exception to this trend was a qualitative investigation of six couples with histories of mild to moderate PD in Australia (Everingham et al., 2006). Results of their inquiry using frame analysis suggest that mothers and fathers apply different frames to their explanations of PD, potentially impeding communication and understanding between the parents. Further evaluation of parenting pairs' similarities and discrepancies in PD symptom conceptualization is needed to understand how partner consultation might fit into the growing literature on the gap between detection and treatment of PD.

1. Current study

Despite growing evidence that partners are commonly consulted about PD symptoms, relatively little is known about the process or characteristics of these mother-partner consultations. Previous work has been limited primarily to mothers who self-identified as depressed or have been formally diagnosed or treated. Though informative, this approach limits our understanding of the illness conceptualization process to women who have ultimately accepted or been given a medical conceptualization of symptoms (depression). As the goal of the current study was to understand how women and their partners evaluate and respond to maternal mood changes, the purposive sample included women representing a broader range of symptom severity and treatment seeking behaviors. A small number of cases of single mothers were included to provide contrast with couple interactions. Qualitative methodology was chosen to match the exploratory and open-ended nature of the research question: How do mothers and fathers describe the process used to detect, evaluate, categorize and respond to maternal mood changes in the first postpartum year? What role, if any, do fathers play in this process?

2. Methods

2.1. Purposive sampling and role of contrast cases

Purposive sampling followed the qualitative study approach suggested by Axinn and Pearce (2006, p. 31), which suggests that the question of interest—in this case, how mothers and fathers evaluate maternal mood changes—should define the characteristics of the sample before beginning the sampling process. Axinn and Pearce (2006) argue that in order to adequately evaluate the process of symptom evaluation in couples, a smaller contrast sample of mothers without partners should be included, as well as a contrast sample of mothers who did not experience elevated depressive symptoms. The inclusion of these two contrast groups is not to expand the research question to all mothers, but rather to gain more accuracy in identifying themes and processes uniquely present in the symptomatic couple context, as well as those themes that represent maternal mood evaluations across symptom severity and relationship status. Partnered parents with significant maternal PD symptoms (EPDS$\geq$10) at one of four time points in the postpartum year) comprised the largest selected cell of the planned sample, contrasting with smaller cells of low maternal PD risk