TITLE: Enablers and barriers to seeking help for a postpartum mood disorder

RUNNING HEAD: “Enablers and Barriers”

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Key words: postpartum mood disorders, help-seeking behaviours, barriers, enablers

ABSTRACT

Objective: To explore the barriers and enablers identified by women experiencing a postpartum mood disorder (PPMD) that both preclude and facilitate their help-seeking behaviours 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 (1998).

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 which influenced their help-seeking behaviours. Through navigation of both formal and informal help, women were able to begin the journey to reclaim the mothering soul 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.
Callouts

1. Postpartum mood disorders represent a complex class of illnesses that may result in serious implications for new mothers but can also consume those around her.

2. This use of the label of ‘having postpartum’ provides safety for women in a society where the stigma around mental illness remains deeply entrenched.

3. Women need their physical health monitored appropriately but also need emotionally supportive care that values and honours the needs of both women and their babies.
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 B.C. 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 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 has been on 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. Post traumatic stress disorder 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 10-40% worldwide (Holopainen, 2002). More commonly however, it is estimated that approximately 10-15% of new mothers experience a mood disorder and is the most frequently occurring illness experienced by women in the puerperium (Barr, J.A., 2006; Pearson, R.M., Cooper, R.M., Penton-Voak, I.S., Lightman, S.L. & Evans, J., 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 four 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 posttraumatic stress disorder 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 mother’s experience a posttraumatic stress disorder (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 which 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 reduce 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 her infant, both short-term and long-term sequelae from exposure to maternal mood disturbances may ensue with an increased risk for neglect, higher accident and

By 12-18 months of age, cognitive delays, particularly for male children, are often apparent (Tronick, E., 2007). Longitudinal studies have evaluated the emotional, cognitive and behavioural effects of exposure to maternal mood disturbances and have indicated that the effects are enduring. By age 11, both male and female children present with lower IQ scores, attention problems, conduct disorders, and difficulties in mathematical reasoning (Hay, Pawlby, Sharp Asten, Mills & Kumer, 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, PPMD’s represent a complex and multi-faceted class of illnesses that may result in serious implications for new mothers but can also cascade to consume and threaten those around her (Gold, 2002).

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 us 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, our understanding of help-seeking behaviours in women experiencing a PPMD remains largely undeveloped. Grounded theory is a recommended method of inquiry for areas where 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 epistemological goals of generating nursing knowledge, promoting theory development, and informing practice (McCreadie & Payne 2010; Meleis, 2005). Therefore, the use of grounded theory as a means of increasing our knowledge of the perceived barriers and enablers that direct women’s help-seeking behaviours 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 Depression Support Group (M.O.M.’s) was based. A public health nurse (PHN) served as a liaison to direct and facilitate the recruitment of interested participants at Well-Baby Clinics. The inclusion criteria for participation in the study included: a) women had to be at least 18 years of age b) English speaking c) had given birth to a healthy, full-term infant within the last 24 months d) no history of a serious pre-existing
psychiatric illness prior to the development of a PPMD e) been formally diagnosed as having a PPMD by a physician or f) not have been formally diagnosed with a PPMD by a physician but who were experiencing symptoms which they identified as intrusive and disabling to their functioning as mothers. All the women who self-identified as having a PPMD did experience some combination of symptoms which included extreme sadness and tearfulness, irritability, thoughts of harming themselves or their infants, difficulty concentrating, weight loss or gain that was not explained by normal somatic changes associated with the postpartum period, or sleep difficulties which were not related to infant care issues.

Recruitment to the study began in October 2003 and continued through to February 2004 when it was determined that theoretical saturation had been achieved. In the end, 10 women who met the inclusion criteria participated in the study. A purposeful sampling technique was used at the beginning of the research project which was then superseded by theoretical sampling (Bryant & Charmaz, 2007). Two participants were recruited through the PHD, 2 through the postpartum depression support group (M.O.M.’s), 1 through referral by a doula who had seen the recruitment poster and 5 through snowballing.

A semi-structured interview guide was developed to provide some direction to the researcher but during interviews women were invited to openly tell their stories to ensure their voices were heard and their experiences shared without a rigid adherence to the interview guide (Charmaz, 2006). Each interview started with the broad opening question of ‘tell me what you pregnancy was like’ which served as a port of entry into this significant experience in a woman’s life. All interviews were completed by a single
researcher and conducted in the participant’s homes at their request. At the end of the first interview, all of the women were asked and agreed to participate in a second interview to provide a ‘member check’ and validate the findings following analysis of the data. All taped interviews were transcribed verbatim by the researcher to ensure further immersion in the data. Observational notes and journal reflections were maintained throughout data collection and analysis to supplement the in-depth interviews (Charmaz, 2006). These served as important resources during data analysis to stimulate further ideas and discussion between the researcher and her supervisor as well as the thesis committee.

**Data Analysis:** Data analysis occurred through the ‘constant comparative method’ with data being analyzed in a circular fashion in keeping with the methods described by Strauss and Corbin (1998). Data were collected and analyzed concurrently with labelling of the data beginning immediately after each interview had taken place to allow the researcher to become sensitive to the incoming conceptual ideas. Transcripts were reviewed line-by-line with each discreet idea or concept given a label. Where it was possible, in vivo codes or direct quotations from the data were used to better represent the emerging conceptual ideas (Strauss & Corbin, 1998). Emerging concepts were clustered together and then collapsed into more abstract categories as analysis progressed. During the final level of analysis, the core category was selected and the relationships between all other major categories were filled in. All of the initial interviews were coded by the researcher and her thesis supervisor together. After the first set of interviews were completed and analyzed, the findings were then reviewed with the researcher’s thesis supervisor and committee members together to check for logical flow of the findings.
In order to ensure the quality of a grounded theory study, four criteria must be present (Glaser & Strauss, 1967, p. 237). These properties include: fitness, understanding, generality, and control. The criteria of fit and understanding were met by doing ‘member checks’ to ensure participants could provide comments on the emerging theory. All of the participants were contacted within 6 months of their first interview to allow for feedback and validation of emerging themes. Peer debriefing with nursing colleagues also provided an avenue for reflection and evaluation. Both participants and colleagues provided feedback that indicated that the theory was easy to understand and ‘resonated’ with both their personal and professional experiences.

The property of generality was met by gathering both sufficient amounts of data from a diversity of sources which included not only information from participants but also through ongoing consultation with several public health and mental health nurses. The final criterion of control was attained by developing both general and specific interventions to direct care around pregnancy and the postnatal period for potential users of the substantive theory to help in the management of a woman with a developing or present PPMD.

**Ethical Considerations and Approval:** After receiving approval from the affiliated University Human Ethics Board, ethical approval was then sought from the Public Health Department (PHD) Human Ethics Board of a large Canadian city. Given the sensitive nature of examining PPMD’s, an action plan was developed to assess whether women were experiencing either no distress, mild distress, moderate distress, or severe emotional distress. Women were assessed using a basic mental health status exam to evaluate such factors as thought content and safety in relation to themselves and their
children to determine whether inclusion within the study was appropriate. Within this sample, the only intervention that was necessary for the participants was to provide psycho-educational support. Informed consent was obtained from all study participants and each participant was given an identification number for purposes of anonymity. The tapes and transcripts have been locked in a safe location and will be destroyed 7 years after completion of this research project.

Findings

Participants: The 10 women who participated in this study were a relatively homogenous sample. They were mature (mean age=32.6 years with a standard deviation of 2.011), well educated, Caucasian and economically middle-class. All of the participants were married and English speaking with the exception of one woman whose first language was French although she was fluently bilingual.

At the time of the first interview, 6 of the participants had 2 children, 2 of the participants had 1 child but both were in their 3rd trimester of a second pregnancy, and 2 of the women had a single child. The ages of the children at the time of the first interview ranged from 7 months to 3 years. Two of the 6 participants who had 2 children at the time of the first interview had experienced a PPMD after each baby. Two of the participants with 2 children experienced a PPMD after the first baby only. One of the participants with 2 children experienced a PPMD after the second child only. One participant with 2 children experienced a PPMD that began after the first child and did not resolve through the second pregnancy and continues to be treated. At the time of the second interview, both mothers who were pregnant at the first interview had given birth to their second children and both were experiencing significant symptoms of a PPMD.
again. Of the two remaining participants who had single children, one woman had
consciously decided not to get pregnant again as a direct result of her experience with a
PPMD. The remaining mother was in the process of planning her second pregnancy but
was methodically reviewing her experience to arrange and organize for the appropriate
resources to be in place before she would actively attempt a pregnancy again. The ages
of the children at the time of the second interview ranged from 3 weeks to 3 ½ years.

In terms of use of obstetrical service providers, 5 of the participants had shared care
with their family physicians and obstetricians, 2 received care from their family
physicians and obstetricians while employing the additional services of a doula, and the
remaining 3 participants used midwife services exclusively. Eight women gave birth
vaginally and 2 delivered by caesarean delivery. All of the participants initiated breast-
feeding while in hospital. Of the 10 women in the study, 8 sought out professional help
while 2 relied exclusively on the support of lay others for resolution of their PPMD. All
8 who received professional attention were diagnosed as having a mood disorder and
were prescribed pharmacological therapy for their illness. Of the eight women prescribed
medication, 3 were referred on for individual counselling, 1 returned to a counsellor that
she had previously accessed for a separate depressive episode, and 3 participants attended
a weekly postpartum depression support group for auxiliary assistance in dealing with
their illness. At the time of the second interview, 4 of the 10 participants were continuing
to experience some moderately debilitating symptoms, 3 women were experiencing
mildly distressing symptoms and 3 participants were virtually symptom-free.

The Core Category
Following a protracted involvement with the data, the core category of ‘Having postpartum’ emerged to capture the experience of seeking help for a PPMD and refers to a process across time from the inception of the mood disorder through to varying levels of recovery. This is the terminology used by mothers to identify their illness. It provides a label for the disease process while at the same time removing it from the mental illness spectrum. There is no qualifier attached to the title. For in fact, all women who give birth have ‘postpartum’. This use of the label of ‘having postpartum’ provides safety for women in a society where the stigma around mental illness remains deeply entrenched.

Samantha: Saying ‘postpartum’ just sounds better. Kind of less serious. Like it still sounds bad but I don’t know…. If it just wasn’t so tied to the word ‘depression’ because that is just so stigmatized.

Four main stressors were also identified by the women as significantly influencing their mental health and contributed to their downward spiral into a PPMD. These factors included: 1) An unplanned or unsupported pregnancy 2) Lack of identification of risk for developing symptoms of a PPMD and/or delayed diagnosis 3) A traumatic birth experience and 4) Breast feeding difficulties. Two barrier categories and a single enabler category were further identified by the women as influencing their help-seeking behaviours. The barrier categories include: 1) stigma and 2) health care provider issues. The enablers identified by women were collapsed into a single category that was all encompassing titled ‘comprehensive maternal-child care’ which fundamentally represented a philosophy that fully embraces holistic care from health care providers.

**Significant stressors that contributed to the development of a PPMD**
Pregnancy is in and of itself a significant emotional and physical event in a woman’s life. The stressors that women who participated in this study identified as contributing to the development of a PPMD are consistent with those found in the literature (Beck, 2004; Cohen & Nonacs, 2005; Forman, Videbeck, Hedegaard, Salvig & Secher, 2000; The Maternity Centre Association, 2002). Some participants talked about the experience of an unplanned or unsupported pregnancy resulting in considerable emotional turmoil and ambivalence leaving the mother with a wash of negative emotions while laying the foundation for the beginning symptoms of a mood disorder (Rich-Edwards, et al., 2006). For some women in the present study, a previous history of a PPMD or symptoms of a mental illness were clearly developing or were exacerbated during the pregnancy and were not identified or treated in a timely fashion. This has also been shown to be a strong predictor of the development of a PPMD in the literature (Dennis & Chung-Lee, 2006; Watt, Sword, Krueger, & Sheehan, 2002). Many women identified what they would describe as a traumatic birth experience as the single greatest event that triggered the beginning of the spiral into the darkness that defines the illness (Beck, 2004; Benoit, Westfall, Treloar, Phillips, & Jansson, 2007). Finally, a number of participants also identified breast-feeding as a tremendous stressor that contributed significantly to the development or worsening of symptoms. All of the participants attempted to breast-feed and stated that the “extreme societal pressure” to breast-feed at any cost because all ‘good’ mothers should very much impacted their decision to start and provided tremendous guilt in the event that they felt unable to continue (Wall, 2001). Being aware of and attentive to these stressors for women which may contribute to the development of a PPMD is critical and has significant implications for nursing practice.
Barrier categories to seeking help for a PPMD

The category of stigma represents an in vivo code with women speaking often of the shame associated with having a mental illness. As a result of the stigma and shame that continues to plague those with mental illness, the mothers identified it as a significant barrier to reaching out to both professional and lay help which often begins only when symptoms are no longer manageable. When rebuffed by others for expressing their concerns, women were left shaken and forced to manage symptoms on their own.

Invalidated feelings by a close significant other were particularly painful.

Maggie: I think the biggest one was with my husband. I was worried that he would look at me as “Oh, she’s not doing a very good job” and my in-laws too “Oh, she can’t cope and she’s not doing a very good job as a mother” and I always had in the back of my mind that if something ever happened between my husband and I that he would get the kids cause I’m just not doing a good job.

The category of health care provider issues developed as a result of no single discipline being responsible for women’s mental health concerns during the perinatal period. Despite frequent contacts with various health care providers (e.g. physicians, nurses, midwives) symptoms go largely unnoticed without one discipline specifically addressing and monitoring these issues. It also leads to confusion for women as to who they should reach out to for professional help. Without professional ownership for assessing and managing mental health of women throughout the perinatal period,

Lynn: My six-week visit? It was a waste of time. An absolute waste of time. She went in, I got weighed, she saw the baby and said “Oh, how cute!” and then that was it.
Absolutely no questions about how I was feeling at all, at all. It was a social tea. It was a social tea with somebody who is really afraid to ask you if you are feeling “blue” because then you will take up too much of their time.

As an extension of *health care provider issues*, a lack of knowledge/ awareness was demonstrated by many health care providers and laypersons about PPMD’s. PPMD’s can configure and present themselves in many different ways and often begin prenatally. A lack of knowledge about when these illnesses may begin and the extreme variability of symptom patterns may leave practitioners and significant others unprepared to identify problems as they appear. Lack of knowledge/awareness about PPMD’s was also apparent once a PPMD was identified as pharmacological intervention was offered as the only solution to most of the women who sought professional help. Few were given the option of supportive conjunctive therapy. This was a significant barrier for women as they described a strong distaste for pharmacological intervention and often delayed the women from seeking treatment because they felt that they would be offered medications for symptom management and that this would solidify the depth of their illness, prevent them from continuing breastfeeding or be the only option available to them.

Darcy: So, I went for my six-week postpartum check-up at eight weeks. I was a couple of weeks late but I saw the guy, you know, the OB who did the c-section and he just basically looked at me and like I was bawling in his office and crying and telling about my experience and my fears and he gave me a prescription for antidepressants then he just wrote me a bunch of repeats for the Zoloft and offered no-follow-up.

Mothers strongly felt that pharmacological intervention alone was unsuitable and served as a ‘quick fix’ or ‘band-aid’ to the reality of their illness. For these mothers, the
fear of treatment served as a significant barrier and impacted their decisions when determining if and when to seek professional help.

Eventually, for many women, the symptoms worsened and the length of time between episodes became shorter making the need to get help more apparent. This is a significant barrier for women in seeking help and is linked to the category of health care provider issues in that the periods of waxing and waning would be less deleterious if a professional group was monitoring a mother’s mental health over a period of time to capture the big picture.

**Enabler categories to seeking help for a PPMD**

The enabler category of comprehensive maternal-child care reflects a system of care that fully meets the physical, psychological, and emotional needs of the mother-child dyad. By shifting care beyond the physical parameters of obstetrical care, women felt it would create a safe place for them to seek help for their symptoms through open dialoguing and ultimately reduce the stigma and hidden nature of mental illness during the perinatal period. By working to shift society’s views around mental illness and mothering, receiving help would not be seen as a failing but as ‘normal’. This was described as a significant enabler to the help seeking process and is reciprocal in nature to the barrier category of stigma.

Samantha: I don’t even remember it coming up [prenatally]. Maybe just briefly. But ya, certainly if they made moms and their partners more aware of the possibility and where to go if it does happen and stuff. I guess just really make it open and there. Make it okay to talk about. This whole mental illness thing is really just so stigmatized and it’s really sad.
As part of comprehensive maternal-child care and the transition to making mental health care an equal priority to the physical care that is given was a strong desire to integrate screening for PPMD’s. Just as screening for diabetes prenatally is a standard part of care, women want screening for mental health to be integrated as the standard of care.

Zola: I think it needs to be a standardized thing. Just like a gestational diabetes screen. You know, they don’t just do it on the fat women; they do it on the skinny women, right? If it was a standard thing that they gave every woman between 36 and 40 weeks and that they continued to do it during the follow-up that would be good.

For all of the women who participated in this study, none were screened with a screening tool for a mood disorder at any time during the perinatal period. This would have served as a significant enabler to identifying the presence of symptoms earlier in the course of the illness as women felt that the implementation of a standardized system of screening for depression or mental illness in general should be a regular part of their care.

The integration of screening as part of a system of comprehensive maternal-child care responds to many of the elements found within the barrier category of health care provider issues.

The final significant element of truly comprehensive maternal-child care system, requires that health care providers embrace mothers and babies as a single unit of care such that women feel equally valued to their children. In creating this environment, mothers would feel that their concerns would be validated and seen as a similar priority. Through adhering to this philosophy, women would have their concerns validated early
and often. This would greatly enable the process of feeling safe to disclose the illness
experience.

Zola: It’s not about you. It’s not about me. It’s not about the woman that is having
the baby. They are just there to make sure that the baby is okay, the baby is growing, and
it’s all about the baby. The baby, the baby, the baby.

Discussion

The clinical implication of these findings for nursing requires that we alter our
practice to more adequately meet the needs of women during pregnancy and in the
postnatal period. It is important that we acknowledge stressors that women have
identified as contributing to the development of their PPMD. This should direct our
practice by giving us important opportunities to ask women without judgment about the
emotional impact of their pregnancy, previous mental health issues, birth experiences,
and breast-feeding issues. This may provide helpful insight into the mental well-being of
a woman and allow for open and safe discussions in various clinical contexts. The
continuing stigma and shame associated with having a psychiatric illness serves as a
significant barrier for women to seek out help from both lay and professional others when
experiencing a PPMD (Pinto-Foltz & Logsdon, 2008). In this study, the mothers spoke
often of the stigma around mental illness that forced them to hide and mask their
symptoms and negative feelings around mothering ultimately diminishing their quality of
life. At the same time, in delaying their treatment to avoid judgement from others, they
identified that their interactions with their children were often markedly compromised.
Maternal mood disorders greatly diminish the quality of the interaction between the dyad
ultimately resulting in emotional, social, and cognitive delays for their children (Luoma,
Tamminen, Kaukonen, Laippala, & Puura et al. (2001). The outcomes for children are particularly compromised and correlated with the chronicity of their mother’s illness indicating that delayed treatment has significant long-term implications for the dyad and family unit as a whole (Hay, Pawlby, Sharp, Asten & Mills et al., 2001). These findings highlight the urgency in detecting and treating mental illness within this population while also giving strong evidence that women want to be asked open and direct questions around their mental health.

The finding that maternity care should be delivered within the context of the mother-child dyad as the unit of care is an important one. Our current system often places primary focus on the health and wellness of infants to the exclusion of their mothers. Women need their physical health monitored appropriately but also need emotionally supportive care that values and honours the needs of both women and their babies. This philosophy of care highlights the necessity for a holistic approach with the dyad together as a focus throughout this life event (Health Canada, 2002).

Women very clearly identified that they wanted universal screening for mood disorders to be implemented as part of the standard of practice for maternity care. Screening for mood disorders is a simple and economical process that is well within the scope of our nursing practice allowing us to take ownership for not only its implementation but also to be leaders in advocating for this best practice standard to be available to all women. The design and delivery of mass screening programs for perinatal mood disorders will require the concerted effort of maternal-child nurses, public and community health nurses and other nurses who work directly with this population.
The most significant limitation of the study findings is that they are not generalizeable beyond the present participant sample. The mothers who participated within this study were all well educated, white, mature (mean age = 32.6), professional women with few financial or social limitations. Further, all of the participants had partners who were able to provide at least minimal instrumental and emotional support. For new mothers without these financial, emotional, and social benefits, the experience of a PPMD would undoubtedly be more profound and complex (Beck, 1996). As a result, the study findings must be transferred to other populations with considerable caution.

**Conclusion**

In listening to women’s voices, we now have a greater understanding of the barriers that prevent them from seeking help for a PPMD. Further, by directly asking mothers how the process can be enabled, the women have provided solutions towards improving care around their mental health needs during this important development life stage. This may be best achieved through providing screening for all women across the perinatal period. This should also facilitate making women’s mental health a priority within the context of a safe and open environment for disclosure of symptoms while enabling women to reclaim their mothering souls.
References


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