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Women's experiences of perinatal depression: Symptoms, barriers and enablers to disclosure, and effects on daily life and interaction within the family

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ABSTRACT

Objective: Nearly half of all cases of perinatal depression are not detected, despite routine appointments with healthcare professionals (HCP) during pregnancy and after childbirth. Early identification of perinatal depression is crucial to provide the required support and offer timely treatment. This study aimed to explore women's experiences of perinatal depression to help identification and management of perinatal depression by HCPs.

Design: Theoretical perspective of symbolic interactionism and methodological design of ethnography was adopted. Face-to-face individual interviews were used. Thematic analysis was conducted to analyse interview data.

Participants: Fifteen women who had experienced perinatal depression in the last five years were interviewed.

Findings: Three themes were identified: 1) Getting closer to the perinatal depression; 2) Decision to disclose or hide real feelings; 3) Hidden face of perinatal depression.

Key conclusions and implications for practice: Findings demonstrate the importance of HCPs' attitudes towards women, as if women perceive they being dismissed or neglected by HCPs, may have an impact on women refraining from disclosing their feelings.

Introduction

Depression is one of the most common mental health disorders in the perinatal period (Howard and Khalifeh, 2020). Perinatal depression is of critical importance because of the potential risks they represent to women and their families if they are not identified and left untreated (Howard and Khalifeh, 2020). Adverse outcomes (e.g. prolonged morbidity or deterioration in symptoms) for women and other family members may occur if the diagnosis delays (Bauer et al., 2014; Obe, 2015). The National Maternity Review (National Health Service England, 2016), published by English Government summarises the gaps in the evidence regarding the challenges of identifying perinatal depression, and the need for education and training for HCPs with regards to identification and management of mental health disorders. Indeed, nearly half of all cases of perinatal depression could not be detected, despite routine appointments with HCPs during pregnancy and after childbirth (4Children, 2011; Bauer et al., 2014). Some health professionals may experience difficulty in detecting depression because of limited knowledge or skills or confidence in talking about women's mental health or due to workload (Jomeen et al., 2009; Noonan et al., 2017; Rothera and Oates, 2011). Women may also abstain from talking about their feelings to professionals because of the stigma of mental health issues (Bilszta et al., 2010; Button et al., 2017; Forder et al., 2020; Hannan, 2016; Khan, 2015). Other explanations include women's worry about the involvement of social care, which may result in loss of custody over the child (Dolman et al., 2013), or choosing to deal with their mental health themselves (Woolhouse et al., 2009).

An international qualitative systematic review of 40 articles conducted by Dennis et al. (Dennis and Chung-Lee, 2006) examined postpartum depression, help-seeking barriers and maternal treatment preferences. They found that women do not tend to

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disclose their feelings and that they lacked knowledge about the symptoms of depression (Dennis and Chung-Lee, 2006). The authors concluded that knowing what the barriers are to seeking help is important in order to strengthen relationships between health professionals and women, and to develop preventive and treatment approaches that are in accord with women's preferences and needs (Dennis and Chung-Lee, 2006).

Although these findings highlight the difficulties of identifying perinatal depression, the studies had insufficient information about women's experiences of perinatal depression and the enablers or facilitating aspects of talking with women about their low mood and the barriers related to that. This qualitative study therefore aimed to explore women's experiences of perinatal depression to better understand their perceptions of their illness, the barriers and enablers to disclosure of their real feelings, and its influence on their daily life and communication within the family, in order to help with the identification and management of perinatal depression by HCPs.

Methods

This study was reported using the Standards for Reporting Qualitative Research framework (O'Brien et al., 2014). To address the research aims outlined above, a qualitative paradigm was chosen (Barbour, 2014; Ritchie et al., 2014). The theoretical-methodological perspective of symbolic interactionism (Blumer, 1998) was adopted to focus on how people describe their world with perinatal depression and how that explanation shapes their action(s) (Charon, 1998). The theoretical perspective of symbolic interactionism is congruent with, and often employed within, the methodological design of ethnography. Ethnographic interviews are essential for learning about a particular group of people's needs, perspectives, work processes, preferences and activities, alongside the generation of descriptive data through prolonged fieldwork, acknowledging the researcher as the principal research instrument (Hammersley, 1998; Hammersley and Atkinson, 2007). These approaches were deployed to better understand the meaning of perinatal depression and its influence on individuals' social actions and how/whether these meanings and understandings were shared amongst the women.

Mirroring of the self during the research process and reflecting on feelings, impressions, preconceptions, beliefs, values, activities and observations in the field, and clearly indicating each step of the process has critical importance in the interpretation of the outcomes (Barbour, 2014; Potvin et al., 2010). This is the basic principle of reflexive accounting. As a researcher undertaking ethnographic work, the main objective was to gain insight into the participants' symbolic life world and to endeavour to reflect on their experiences. The researcher believes that this objective was met through building trust and a sense of privacy with the women, which enabled them to be honest and open about their experiences. At the same time, the researcher found herself touched by the intense feelings that were expressed during the interviews and impressed by how these mothers endeavoured to deal with their unique personal challenges.

Study settings, sampling and recruitment

Women were recruited through advertisement posters placed at local hospitals (three areas within Yorkshire and the Humber) and online advertisements posted on selected, relevant websites and Facebook accounts related to mothers. Telephone and email addresses of the first author were provided on the advertisement posters, so that women could contact the researcher to receive further information or participate in the study. When a woman called or sent an email, saying that they would like to get further information or take part in the study, the researcher gave them information about the study and explained the ethical considerations. The phone number and address of those wanting to participate in the study were then recorded on a spreadsheet of contact details and the information pack was sent out by post. All potential participants were sent an information pack by mail including a pre-paid stamped-addressed return envelope. They were able to read the participant information sheets before informed consent was sought and obtained. Only those who returned their signed consent form by mail were considered.

A purposive sampling method was used to identify women who would be able to provide reliable information on the topic (Thorne, 2008) and to recruit a small number of women who represent a wider community, in order to understand the main problem being studied (Patton, 2015). Women who either had felt or been diagnosed with depression during pregnancy or in the first year after childbirth within the last five years met the key inclusion criterion for the study. They 'either had felt or been diagnosed with depression' was the phrase used because women may not choose to seek help from HCPs and perinatal depression might be undiagnosed.

The researcher was very aware that the mental health of women was of critical importance and that the potential participants may bring difficult life experiences to the interview situation. It was for this reason that assessment and management of risk protocol was prepared and only participants who scored below 10 in the Patient Health Questionnaire-9 (PHQ-9) (Kroenke, Spitzer and Williams, 2001) were recruited rather than women in the perinatal period or women who were symptomatic at the time of the enrolment.

Sampling, transcribing and analysing were carried out iteratively until no or few new codes and themes identified from the data (Patton, 2015). Ethical approval was granted by Yorkshire and the Humber – Leeds West Research Ethics Committee (IRAS ID:237,021; REC reference:19/YH/0004).

Data collection methods

Individual face-to-face interviews were used to obtain women's experiences of perinatal depression. Interview topic guides were developed through engaging with the literature, the recommendations of authors and the recommendations of the local Patient & Public Involvement group. Study design and methods of recruitment to maximize data collection from women were developed through liaising with a research midwife and a research nurse who worked in a Research and Development department at a local, participating NHS Trust. All recruitment materials (poster and leaflets, participant information sheets, consent forms, demographic forms and contact details sheets) were improved with the involvement of two mothers to better explain the study to future potential participants.

Interviews were conducted by the first author. All interviews were audio-recorded by the researcher with a password-protected audio recorder. Interviews were transcribed verbatim by the researcher or a professional transcriber and transcripts checked for accuracy with the audio and amended as needed. Private interview rooms within four community centres, situated in convenient locations for the women, and provided privacy and confidentiality, were hired for the interviews with four women. Nine women requested to be interviewed at their home, one in her workplace and one in a private bookable room at a university. Safety risks to the researcher may be posed when interviewing participants at their homes. The institutional 'Lone working policy' was followed to diminish the risks to the researcher. The duration of interviews ranged between 25 and 65 min, with an average

of 40 min. In recognition of the women's time and effort in the study and as a thank you gift, they were given a One4all gift card worth £20.

Data analysis

NVivo 11.3.2 was used to manage and analyse the qualitative data (IT Services and University of York, 2017). The reflexive thematic analysis was used to identify the commonalities and patterns from individuals' verbatim transcripts (Braun and Clarke, 2013). Coding using reflexive thematic analysis is an iterative process and not stabilised to predetermined codes. The initial codes can be merged with other codes and can be recoded or separated into other codes. The purpose of making these changes is to better capture the essence and the meaning lying under the surface. Braun and Clarke describe six phases of thematic analysis: familiarisation with the data, generating initial codes, generating themes, reviewing themes, defining and naming themes, and producing the report (Braun and Clarke, 2019). These steps were carried out during the analysis process.

Findings

Fifteen women took part in individual interviews in 2019. All the women were white British, aged 28 – 41 years (mean = 34.0 years). Over two-thirds of them (n = 11) were married or living with a partner and under one-third of them were single (n = 4). Over two-thirds had completed graduate study (11 = graduate; 2 = left full time education aged 16; 2 = postgraduate) and nearly all (n = 13) were working in a part-time job (1 = full time; 1 = not working). Two-thirds of women (n = 10) had one child (five had two children) and the youngest child was aged 1 – 4 years old. The mean age of these children was 2.3 years. Women's scores on PHQ-9 varied between 0 and 6 (n = 15), and the mean score was 2.07.

Over half the women (n = 8) reported experiencing *perinatal* depression. Six had been formally diagnosed, and two women did not have a diagnosis of perinatal depression. The reported duration of perinatal depressive symptoms varied from two months to three and a half years. For a few women, the depression symptoms during pregnancy were occasional and did not appear after giving birth until a few months later.

Just under half the women (n = 7) reported experiencing only *postnatal* depression. Five had a diagnosis of postnatal depression while two women had not. The duration of postnatal depression symptoms ranged from five months to three years.

Over one-third of women (n = 6) described experiencing anxiety at some point during pregnancy and/or in the postnatal period in addition to depression symptoms. Almost two-thirds of women (n = 9) stated in the interviews experiencing depression (n = 3), low mood (n = 2), anxiety (n = 1), low mood and anxiety (n = 1), depression and anxiety (n = 1) and an eating disorder (n = 1) at some point in their life before their pregnancy or in their previous pregnancy; however, over one-third of them (n = 6) did not state these problems in their demographics form, which shows the advantage of conducting interviews compared to asking participants to complete surveys.

After analysing the transcripts thematically, the following three themes identified from the data, which were the most frequently highlighted patterns related to the women's experiences of perinatal depression: 1) Getting closer to the perinatal depression; 2) Decision to disclose or hide real feelings; 3) Hidden face of perinatal depression.

Getting closer to the perinatal depression

The women described having some triggers in their lives as the major reason for their *antenatal* and *postnatal* depression experiences. The mostly reported triggers of *antenatal* depression were: pregnancy-related symptoms (e.g. morning sickness, hyperemesis, tiredness, sleeping problems); lack of support from their partner, family or friends; history of depression and/or anxiety; and history of infertility or having miscarriages.

> *"…I didn't have any support or anybody and I was shopping for things on my own, all the baby clothes and I wanted somebody to share things with and there was nobody there so that sent me depressed really. No friends or anything. My family could have come but they were too far away…"*

The mostly reported triggers of *postnatal* depression were: struggling to get used to a new life with a new-born (e.g. sleep deprivation, problems with breastfeeding, finding hard to manage housework and personal care); struggling in the transition to be a parent (e.g. changes in their roles, unsupportive partner, feeling like a bad mum); physical and mental birth-related complications (e.g.. birth trauma, a perineal tear); and hormonal changes and baby blues.

> *"…just that I was a bad mum and that I wasn't cut out for it, mainly that but I was just like..I didn't feel like a mum, if that makes sense…"*

Women reported experiencing difficult situations before becoming pregnant, during pregnancy or in the postpartum period, as explained above and developed depressive symptoms with/without anxiety as a result of that. The most commonly used words to describe their feelings *during pregnancy* were feeling: low, depressed, down, tired, exhausted, sick, emotional, worried, anxious, awful, rubbish and isolated. Most women expressed not feeling excited about their baby. They reported being unwilling to go out, to socialise with other people, to talk to someone and to do anything; therefore, there was a decrease in their activities and communication within the family and with others. Women's descriptions also included crying without any reason, having poor appetite or eating too much and having sleeping problems.

> *"…I think going from a normal happy quite, I was crying a lot, sleeping a lot and just generally horrible… a couple of times I even had a conversation with my husband to think about ending the pregnancy because I just couldn't cope with feeling that sick anymore…"*

The feelings of women in the *postpartum period* and their description of it was slightly different from those in the antenatal period. Common feelings of women in the postpartum period were feeling: low, depressed, exhausted, emotional, tired, lonely, sad, upset, worried, stressful, anxious and guilty. Women expressed wanting to be alone, to isolate themselves and not to go out, not to see people and not to talk to anyone, because of their depression and anxiety (a few cases). They reported having feelings of not being good enough or not being a good mother and thoughts of '*everyone would be judging them*'. They expressed experiencing a lack of energy and lack of motivation to do anything and as a result of that, the desire to stay in bed and not want to undertake activities such as cleaning, cooking or washing the dishes. Some women stated experiencing poor appetite, sleeping problems, constant crying and bonding problems with the baby. A few women reported having thoughts that they were '*going to feel like that forever*'.

> *"…I just started to just like have no motivation to do anything. I really struggled to get dressed. I'd just sit and watch TV and I*

remember one day we went out for a walk and I just couldn't even walk home… I was crying. I didn't really know why…"

A few women described being more sensitive in the postpartum period when they received comments from other people especially when they went out for shopping and/or other people came closer and told their opinions about how the baby looked like or how he/she was dressed. This situation was reported to be similar within the family when they heard comments from their partner or family members. They reported thinking that others would criticize their ability to parent which led their mood to drop and being very emotional. As one woman stated, *"… My mother-in-law would be like, "oh he doesn't look comfy on ya". That would be it like. I would be crying all night and it was just little things that was a big challenge…"*

Most women were aware that due to hormonal changes, they might experience baby blues after giving birth, while one of them reported never hearing about it before. They described baby blues as starting on the third, fourth day or a week after giving birth and feeling low most of the time. Almost all of them were expecting this to occur and they expressed it as normal and hormonal. However, low mood symptoms continued for weeks and constant crying for no reason started afterwards and they reported that it was not normal to feel like that at that point. As one woman stated, *"…You assume that it's just part of it because you're so tired hence overwhelming and then afterwards I felt it more… People say you get the baby blues. Normal. But I knew it wasn't normal because it just wasn't. It wasn't just sadness, it was complete misery…"*

Table 1
Factors facilitating women's disclosure of their feelings.

Disclosure to midwives
• awareness that the conversation with the midwife would remain confidential • feeling safe to open up to them • trust in midwives that they are trained professionals who can give the correct advice.
Disclosure to health visitors:
• seeing the health visitor at home which is a natural environment for the woman • knowing that they are there 50% to check the baby and 50% to check the woman • feeling that the health visitor is not in a hurry and she has enough time to talk to (spending at least 30 min) • seeing the same health visitor each time and feeling comfortable talking to them and having a rapport with them • picking up on signs that the woman seems sad or asking direct questions to check the woman's mood • scheduling extra visits to the woman's home.
Disclosure to GPs:
• the non-judgmental approach of GP to the woman • the GP to be knowledgeable about the signs, help and support sources and referral processes, and explaining this information to the woman clearly.

Decision to disclose or hide real feelings

While some of the women reported sharing their feelings with their partner, close friends, friends from social media, mother, GP, midwife, health visitor, mother and baby group friends or occupational health services, others expressed hiding it from HCPs and a few of them hid their feelings from their partner and family, while struggling with depression in the antenatal or postpartum periods.

Women who disclosed their feelings, reported finding it very helpful in improving their mood and feeling relieved after sharing. As one woman stated, *"…once you start talking and you meet other mums who've experienced similar things like that you realise how normal it is and yeah that helps…"*. A few women expressed seeking help from HCPs due to pressure from their partners, who recognised the mood changes of the woman and supported her to ask for help from professionals such as midwives, health visitors and/or GPs.

The women reported a range of aspects that facilitated their disclosure of their feelings to HCPs; these are reported in Table 1. These findings show that in addition to being honest to HCPs, HCPs' approach to individual women, seeing the same HCP, spending considerable time, building trust and rapport, had the biggest impact on women's disclosure of their feelings to the HCPs.

"…I'd met her a couple of times before, but it was hard sort of sharing something so personal with somebody you don't know but she [health visitor] did everything she could to put me at ease. Like I say, she had a cup of tea, she sat and we had a really long chat. She gave me her time when I needed it. She probably didn't have a lot of it. So it was difficult but she did.. she was absolutely lovely and she made it quite easy in that situation…"

Some of the women described hiding their feelings from their family and friends because of the following reasons: finding it hard to admit their difficulties; finding it hard to open up to someone; fear of being judged by others and thinking of their experiences as failure. As one woman stated, *"…I think it's hard to admit that you've got a problem in the first place. For me anyway. It's hard to say that you're struggling I think sometimes. When you see like you see other mums and babies and they seem so happy and you see social media and it seems everyone is having a great time and I think it's hard to admit to people that you're not…"*

Some women described the barriers that prevented them from disclosing their feelings to the HCPs. Table 2 summarises these barriers as identified by the women. The patterns in the date highlighted by women were: not being asked about their mood or how they were feeling outright by HCPs; being dismissed or neglected by HCPs when they disclosed their feelings; not being honest about how they were feeling when they were asked about their mood or were given a questionnaire to fill in; fear that social services would remove the child from their care; and fear of being labelled as a bad mum.

"…I remember speaking to the midwife and saying, "I've had depression in the past, I know I'm at risk of postnatal depression, I'm really struggling" and she was just like, "oh it's baby blues, you'll be fine". Never mentioned it. I never saw her again…"

"…So quite often when I went to the midwife for check-ups they were like, "How are things?" "How are you doing?" "How are you feeling?" but I don't think it ever went into how is your mood, you know, how are you coping…"

Hidden face of perinatal depression

Women expressed the effects of perinatal depression on themselves and interaction within the family. These are summarised in Table 3. Some women described struggling with carrying on with the pregnancy because of feeling very emotional and desperate at times and not feeling excited about the baby. A few women did not want to carry on the pregnancy and explained not wanting to be pregnant again because of frightening that they may experience the same feelings again and may not cope at that time.

Most women expressed having problems with bonding with their babies after giving birth and two women reported having thoughts of giving their child for adoption. Women described not

Table 2
Barriers preventing women from disclosing their true feelings.

Related to women themselves:
• not being honest about how they were feeling when they were asked about their mood or were given a questionnaire to fill in • thinking that the HCPs do not care about how they are feeling • fear that social services would remove the child from their care • fear of being labelled as a bad mum • not being able to think rationally while experiencing depression and giving irrational decisions
Disclosure to midwives:
• seeing different midwives each time and could not develop a rapport with them • time constraints of the midwives • being dismissed or neglected by midwives when they disclosed their feelings • the midwives thinking that it is hormonal and normal
Disclosure to health visitors:
• feeling like the health visitor was there for the baby not for the woman • being dismissed or neglected by health visitors when they disclosed their feelings
Disclosure to GPs:
• thinking that the GPs do not care about how they are feeling • the GP saying it is normal to feel like that • the GP's approach to the woman that '*you can't come in here and get a 10-minute appointment and expect to talk about everything that is wrong with you*'

Table 3
Hidden face of perinatal depression.

Challenges that women face during the perinatal period
• struggling with carrying on with the pregnancy (e.g. not wanting to carry on pregnancy, not wanting to be pregnant again) • struggling with bonding with the baby (e.g. not feeling excited about the baby, thoughts of giving the baby for adoption, feeling like losing their identity) • struggling with supporting older child • having suicidal thoughts • conflicts with partner (e.g. poor relationship with partner)

enjoying taking care of the baby, but nevertheless doing it in a mechanical way and feeling like they were losing their identity with the baby, who was dependent on them all the time. They described having a block between them and thoughts about the baby not liking them:

> *"…I think for the first four weeks I found it difficult because I just looked at her like she didn't like me. She hated me. She preferred other people. That made me sad…the first month was really bad. I didn't connect with her at all…"*

Four of five women who had two children expressed that their older child was aware of their depression. As one woman stated, '*the first one, if I cry, she cries. She can see that I'm upset'*. The second woman expressed pretending to be excited for the older child when he told her something; however, she felt that the child could see through this pretence. Another woman reported that she did not want to play with her child when she felt low in mood. The fourth woman described how, because of her low mood, she could not respond to the older child's needs properly.

Two women reported not coping with postpartum depression and having suicidal thoughts; however, no one expressed the intention to harm themselves.

> *"…I thought this is ridiculous. I can't function. I can't do things. I have to really sort things out. It's either do something or do nothing and throw myself under a bus…"*

Twelve women expressed their thoughts that depression affected their relationships with their partners, and some partners also experienced low mood or depression symptoms and some level of anxiety as well. In one case, the partner started taking antidepressants as a result of the woman's depression, and in another case the partner went for marriage guidance counselling.

> *"…I think he felt very sad for me and he was very fearful because he thought that I was going to kill myself. Yeah he was very anxious at that time…"*

Women described having conflicts with their partners due to: poor communication between them; struggles faced by both of them in getting used to a new life with the baby; and partner's concerns about the wellbeing of the woman and putting pressure on her to seek help from HCPs. Other challenges related to partners voiced by women included: thoughts that the partner does not understand her needs; the partner goes back to work after two weeks paternal leave and the mother struggles with taking care of the children and pets on her own, in addition to cooking, cleaning and washing the dishes, without any support from the partner or family and friends. Many women felt resentful towards their partner. This was exacerbated where the partner was perceived as unsupportive and where there were conflicts within the wider family.

Discussion

To the best of our knowledge, this is the first study using qualitative methods and theoretical-methodological perspective of symbolic interactionism to explore women's experiences of perinatal depression and its influence on their social actions, daily life, behaviour, thoughts, relationship with others and interaction and communication within the family. The findings provide a deep and rich picture of the experiences of this population group, than can be obtained through survey methods. Although a previous systematic review (Dennis and Chung-Lee, 2006) explored the help-seeking barriers of women with postpartum depression, the enablers of talking about their mood with the HCPs remained unclear. This study, therefore, captured insights into, and reflections of, women's experiences of perinatal depression in addition to the enablers of disclosing their feelings.

There were a considerably high proportion of women who reported pregnancy or having baby-related factors affecting their mood antenatally and postnatally. For instance, experiencing morning sickness, hyperemesis, tiredness and sleeping problems during pregnancy affected the majority of the women's mood. Being hospitalised because of these reasons or not joining pregnancy classes and other activities that many pregnant women do, made them feel like they were not ready for the baby and the transition to parenthood was described as very hard by those women. The first a couple of postnatal months, especially until moving the baby to her/ his room, were challenging for the majority of women. Being sleep deprived, having breastfeeding problems, lack of physical and psychological support from their partner, family, friends and HCPs on managing their low mood, housework, personal care, baby care and older child care made them feel inadequate to be a parent while all the other mothers seemed to be coping well. Therefore, some of them stigmatised their mood difficulties and felt embar-

rassed that they could not cope with their feelings when they were expected to be happy.

Women's feelings of depression in the perinatal period led to a significant decrease in their social activities and communications with their family and friends. They reported a desire to be alone, not to talk to or see anyone, not to do housework or even cook for themselves or have a shower. These outcomes confirmed recent study findings regarding women's experiences of postpartum depression (Hannan, 2016; Highet et al., 2014). The study described here included a range of experiences, for instance, antenatal and postpartum depression, and described the negative effect of depression on perinatal women's daily routines and activities. The encouragement of women by HCPs to increase their activities when they felt low may help them to break the low mood cycle and overcome their feelings. The symptoms of depression may also be improved through psychological interventions, modified for the specific needs of perinatal women, in order to improve their mood and accomplish their daily routines (Barrera and Castro, 2006).

Some women described reaching out and seeking help from HCPs while others hid it, even from their partners and family members. A few of them ticked the lower score boxes intentionally when given a depression measure to fill in by HCPs. These outcomes are consisted with previous study findings: from the UK which reported that women did not tend to disclose their feelings with the HCPs (Khan, 2015); from Australia which reported that one-fifth of perinatal women had not responded honestly when HCPs asked them about their mental health (Forder et al., 2020) and more than three-fifth of postnatal women were reluctant to share their true depressive feelings with HCPs (Woolhouse et al., 2009); and from an international systematic review which reported that women do not tend to seek help from HCPs (Dennis and Chung-Lee, 2006). Women may be reluctant to disclose their true feelings and seek help because of perceived stigma, worries about the potential involvement of social services, or being dismissed or neglected by HCPs when they talked about their feelings. Previous studies similarly reported that women feel stigmatised and are afraid of being judged by others (Bilszta et al., 2010; Button et al., 2017; Hannan, 2016; Khan, 2015). However, the study described here also highlights a number of enablers that HCPs could use to help women to disclose their feelings to them. Specifically, it may help if HCPs ask every woman in a direct way how they are feeling and how the pregnancy or postnatal period is going at every contact. It may help to make eye contact and make them feel they are being listened to. Having enough time to listen to and respond to a woman if she discloses her feelings was also identified as important and not leaving the conversation there if a woman expresses that she is feeling down. It may help if HCPs checked-in again soon with the woman and not leave too big a gap until the next appointment. They need to make it clear that women might be worried about their feelings, HCPs are there to provide help and support for them to address their feelings, and to give clear messages that mental health challenges do not automatically result in concerns about parenting which would warrant child protection concerns.

The National Maternity Review (National Health Service England, 2016) recommends HCPs to ask about women's mood at every visit. Although the routine screening of postnatal depression has not yet been found to be a factor in changing the help-seeking behaviour of women, the HCPs' attitudes have the biggest impact on women disclosing or refraining from disclosing their feelings (Newman et al., 2019). HCPs need to being open and knowledgeable on perinatal mental health issues to be able to help women to disclose their feelings and encourage them to seek early help (National Health Service, 2015). This is also important in building trusting relationships, not only with the woman but also with their wider family (Forder et al., 2020; Schumacher et al., 2008).

Many women described having bonding problems with their babies and lacking enjoyment with the care of the baby, nevertheless doing it in a mechanical way. Four of five women who had two children reported that their older child was affected by postnatal depression in some way. Moreover, their relationship with their partners was affected as well. Half the women described having conflicts and feeling resentful to their partners because of poor communication between them, struggling to adjust to a new life with the baby, and unsupportive physical help of partners on housework. Indeed, unidentified and untreated perinatal depression may have broader effects on women, their children and partners (Goodman et al., 2011). Early identification of need and management by HCPs, and effective treatments are, therefore, important for the wellbeing of the family. Health care should therefore be family-centred, including partners as well as children (Bateson et al., 2017; Schumacher et al., 2008).

Strengths and limitations

Qualitative methods are powerful in terms of exploring feelings and perceptions, how and why a situation occurs and producing detailed analysis of the target group; however they may be perceived by some as limited because of small number of participants included in the study. The sample size of women who participated in the study was relatively small ($n = 15$), however the key themes were saturated. All women were older than 28 years, and all were white British, thereby limiting the transferability of the findings to younger women or women who were black, brown or from other ethnic minorities.

The women involved in the study were also limited to mothers who had experienced perinatal depression in the last five years and whose youngest child was between 1 and 5 years. Although the priority was to include women who had recently experienced perinatal depression, the youngest child was 2.3 years, which potentially raises the issue of the data being limited over this time period. However, the literature review supported the study findings that perinatal depression is an ongoing problem.

Another challenge in terms of recruiting women was the inclusion criteria regarding women who scored less than 10 in PHQ-9. This information was provided in the emails sent to women who had expressed an interest in participating in the research. As more than half the women who had showed an initial interest did not then respond, it may be speculated that this was due to them experiencing ongoing depression. Therefore, women might continue to experience depression after the end of the postnatal period but the inclusion criteria did not allow them to participate in the study, which was due to ethical considerations for the study. Their experiences, therefore, cannot be assumed to be similar to those women who were involved in the study.

In undertaking qualitative research, the analysis of the data is the most complicated step. The researcher should be aware of their assumptions and their impact on the analytic process, what they are doing and why they are doing it, and their strengths and limitations, all of which affect the trustworthiness of the research and analysis (Nowell et al., 2017). To ensure a rigorous analysis application, a 15-point checklist of criteria for good thematic analysis was used (Braun and Clarke, 2006). In addition, the coding process and thematic map were evaluated by the second author.

Conclusion

This study was aimed to explore women's experiences of perinatal depression in order to aid understanding their perceptions of their low mood, and the barriers and enablers to disclosure of such feelings. The findings provide a rich source of information to better

understand women's feelings and perceptions of perinatal depression and the effects of such feelings on their social actions, daily life, behaviour, thoughts, relationship with others and interaction and communication within the family, which may help identification and management of perinatal depression by HCPs. Furthermore, these findings may be helpful in informing future research and adaptation of psychological interventions for the treatment of perinatal depression.

Ethics approval

Ethical approval was granted by Yorkshire and the Humber – Leeds West Research Ethics Committee (IRAS ID:237,021; REC reference:19/YH/0004).

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Declaration of Competing Interest

The authors declare that they have no conflict of interest.

CRediT authorship contribution statement

Semra Pinar: Conceptualization, Investigation, Formal analysis, Writing – original draft, Writing – review & editing. **Helen Bedford:** Conceptualization, Writing – review & editing. **Steven Ersser:** Conceptualization, Writing – review & editing. **Dean McMillan:** Conceptualization, Writing – review & editing.

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