Users’ views of two alternative approaches to the treatment of postnatal depression

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Abstract  Postnatal depression (PND) is a major public health concern, yet services are lacking. Most women with PND receive routine primary care from general practitioners, health visitors, and in a few cases community psychiatric nurses. A Parent and Baby Day Unit (PBDU) has been developed in Stoke-on-Trent and attendance at this Unit has a greater therapeutic impact on PND than routine primary care (RPC). This small pilot study elicits user views to understand the role of specialist and routine care in PND treatment and pinpoints which aspects of specialist care are important to women. Thirty women with PND attending the PBDU and 30 receiving RPC completed a questionnaire on their views of the service they received. Written comments were analysed thematically using content analytic techniques. The majority of women attending the PBDU were satisfied with this service, whereas women receiving RPC were dissatisfied with their treatment and a perceived absence of information. The main value of the PBDU seems to be one of social support. Effective communication from primary care professionals is important for women with PND and a perceived lack of information is a major cause of dissatisfaction. Availability of peer and professional support is perceived as valuable, but is insufficient within primary care.

Introduction

Postnatal depression can be a serious and debilitating perinatal psychiatric disorder that is equivalent to a diagnosis of major or minor depressive disorder as defined by Research Diagnostic Criteria (Spitzer et al., 1978). Postnatal depression may have a considerable negative impact on the woman and her long-term relationships (Cox et al., 1987); it may have an adverse effect on the family as a whole, and in particular the mother-infant relationship, which may in turn affect infant cognitive and emotional development. Indeed, with an incidence rate of around 13% (O’Hara & Swain, 1996), and a birth rate of almost 700,000 in the United Kingdom, one can suggest a conservative annual estimate of 91,000 cases of postnatal depression per annum. Thus, postnatal depression is a major public health concern.

Despite the numbers of women affected and recommendations for services for
women with puerperal psychiatric disorders (Royal College of Psychiatrists, 1992), these services are lacking (Oates, 1996). GPs have little or no training in mental health (Cole et al., 1995) and often fail to identify postnatal depression (PND). Indeed, research has found that over half of the cases of PND go undetected and subsequently untreated (Cox et al., 1987; Whitton et al., 1996). This may be because clinicians view some of the symptoms of depression, such as not sleeping, weight loss and poor concentration, as normal in the puerperium (Arizmendi & Affonso, 1984). Diagnosis may be delayed by a lack of awareness of PND in general and members of the primary care team in particular (Guidelines in Practice, 2002). Given the frequent contacts for women in the postnatal period, there exists an ideal opportunity for the early detection and treatment of depressive symptoms within primary care and the better use of existing resources for the delivery of appropriate services and treatment.

Routine primary care for women suffering with PND in the UK consists of health visitor and GP contacts, with occasional contacts with community psychiatric nurses (CPNs). In some areas of the UK health visitors are trained to give listening visits which utilize principles of non-directive counselling (Gerrard et al., 1993; Holden et al., 1989). One unique service that does exist for the treatment of postnatal depression is Charles Street, Parent and Baby Day Unit (PBDU). This specialized psychiatric day hospital in Stoke-on-Trent, Staffordshire, England, offers a comprehensive service of individual, high intensity, customized treatment to women with mental health problems associated with pregnancy and within 12 months of childbirth. The PBDU is staffed by a multidisciplinary team of psychiatrists, psychiatric nurses, an occupational therapist and a nursery nurse and offers an individually tailored package of treatments including: pharmacotherapy, individual counselling and group therapies, such as stress management and assertiveness training (Boath et al., 1995; Cox et al., 1993). Research has shown that attendance at the PBDU has greater therapeutic impact on postnatal depression than routine care and is cost-effective (Boath et al., 1999; 2003). Although counselling and group therapy treatments have been suggested to be successful in treating PND (see Boath & Henshaw, 2001), the effectiveness of individual treatments provided within the PBDU has not been evaluated. Although women receive an individually tailored package of treatment at the PBDU, it is important to elicit user views to pinpoint which aspects of the PBDU service are important to women. It is also important to elicit those aspects of the PBDU and routine primary care (RPC) that are perceived to be unsatisfactory.

The quality of clinical services is linked to public/patient consultation (DoH, 1999). Services and the processes of health care are more likely to be appropriate and effective if based on needs identified together with users, carers and the public (DoH, 1997). The concept of service user involvement in the design, delivery and evaluation of mental health services has been refined and now occupies a central position in plans for NHS reform. Despite this, ‘meaningful’ consultation of patients within the NHS is still in its infancy. Traditionally the ‘voices’ of people with psychological problems have been dismissed and devalued. Today, user voices must not only be heard, but also heeded. However, when service users have been consulted about services they have received, or given the opportunity to contribute to decisions about future care, many service users are reluctant to comment on their care in this way, preferring instead to be directed by their mental health professional. The result of this reluctance has often led to decisions about service improvements being led by professionals rather than users and this process has been described as actively undermining their mental health (Jenkinson, 1999). Several reasons for this reluctance have been posited...
including the oppressive nature of medical dominance (Jenkinson, 1999), the stigmatizing effects of mental health care and legislative changes focusing on surveillance and coercive control of ‘madness’ (Pilgrim & Waldron, 1998). The nature of the consultation is also likely to be a major influence. It is unlikely that service users will be comfortable criticizing services received when they are consulted by the professional that manages their care. There will be some concern that any criticism could influence future care provision. It is important that consultation is led by a researcher who is not connected with the service user’s care in any way.

This small pilot study explores the views of two groups of women. One group was receiving treatment at the PBDU and another group who were receiving routine primary care from general practitioners, health visitors and in three cases community psychiatric nurses, which is the model used throughout most of the United Kingdom. The women were participating in a wider study of the cost-effectiveness of services for PND (Boath et al., 2003) and as part of this wider study participants were asked to evaluate the treatment they had received for postnatal depression.

**Method**

A two-stage recruitment procedure was used. The first phase was a broad screening procedure in which staff at the PBDU and health visitors briefly explained the study to all women over a 6-month period who had a baby aged between 6 weeks and 1 year and who scored above the threshold of 12 on the EPDS, and asked if the first author could contact them to tell them more about the study. Staff were all fully informed about the study and a patient information leaflet was designed to facilitate recruitment.

A second phase was necessary to ensure that a clinical depression was present and women who agreed to participate in the research were interviewed by the first author using the Standardized Psychiatric Interview (SPI) (Goldberg et al., 1970). The SPI was used to provide a diagnosis of major (probable or definite) or minor depressive disorder according to Research Diagnostic Criteria (RDC; Spitzer et al., 1978).

The socio-demographic characteristics of the women in the two groups and potential confounding factors such as parity and previous psychiatric history were assessed using a structured interview schedule. The research assessments were all conducted by the first author and a patient satisfaction questionnaire was given to women in their own homes. With the women’s consent, their case notes were reviewed in order to assess the medication prescribed and to provide information on the amount of contact the women had with health professionals during the study period for both themselves and their infants. Six months after recruitment the women were asked to complete a patient satisfaction questionnaire on their views of the treatment they had received for PND at the PBDU and in RPC.

The sample size for the study was calculated using the women’s scores on the SPI. A power calculation estimated that to have a 90% chance of detecting a difference on one standard deviation at the 5% significant level, at least 22 women would be needed in each group. Since the women were being followed up over a 6-month period it was anticipated that some might drop out and so 30 women were recruited into each group.

The 17-item patient satisfaction questionnaire was devised specifically to assess users’ views of the services received for postnatal depression and their ideas of how they could be improved. The questionnaire was based on 10 unstructured exploratory interviews conducted by the first author with women with postnatal depression. Other
items were taken from the Client Satisfaction Questionnaire (Larson et al., 1979) and the Service Evaluation Questionnaire (Nguyen et al., 1983). The questionnaire was not formally validated for this research as many of the questions of interest were unstructured, and the questionnaire allowed for comments on the questions posed throughout. Furthermore, the questionnaire was based on responses from women with PND, thus representing their issues of concern.

Twelve of the 17 items were in a rating scale format ranging from 1 to 4, each point being anchored by a written description that varied between items such as degree of satisfaction or helpfulness. Five open-ended questions were included to allow subjects to express freely their opinions about the services they had received. The women were told prior to filling in the questionnaire that their views would be seen only by the researcher and were assured of the confidentiality of their comments. This creates a ‘safe’ environment within which to express opinions about services and may have enabled women who were not satisfied with their services to describe this dissatisfaction, thus increasing the validity of the data.

Content analytic techniques (Weber, 1990) were employed to structure the comments written by women. First, labels were assigned to concepts that were deemed to be of relevance by the first author. As analysis progressed the concepts were grouped together in meaningful categories, instances of the concepts were recorded and links between the categories were identified.

**Results**

In a naturalistic study such as this, one cannot rule out the possibility that the differences in outcome may be due to pre-existing differences in the characteristics of the women in the two groups. Thus, the socio-demographic characteristics of the women in the two groups and potential confounding factors such as parity and previous psychiatric history were compared using *t*-tests for numerical data and $\chi^2$ for categorical data (Table 1). This revealed that there was no evidence of a statistically significant difference between the women in the two groups in terms of their socio-demographic details, parity, method of delivery or personal and familial psychiatric history (see Boath et al., 1999, for further details).

The number of contacts with GPs ranged from two to 14 (median = six) in the PBDU group and 0–20 (median = five) in the RPC group. The number of contacts with health visitors ranged 0–10 (median = four) in the PBDU group and 0–36 (median = 3) in the RPC group. The number of contacts with GPs and health visitors were analysed using Mann–Whitney U tests. Analysis revealed no evidence of a significant difference in the number of contacts women had with their GPs ($p = 0.50$) or health visitor ($p = 0.74$) (see Boath et al., 1999, for further details). Three of the women in the RPC group had contact with a CPN as well as seeing their health visitor and GP.

Twenty seven women in the PBDU group fulfilled RDC for major depressive disorder and three had a minor depressive disorder at baseline. In the RPC group, 29 women fulfilled RDC for major depressive disorder and one had a minor depressive disorder. RDC diagnoses at baseline and at 6-month follow-up were analysed using $\chi^2$. There was no significant difference in RDC diagnoses between the two groups at baseline ($p = 0.61$) and all 60 fulfilled RDC for major or minor depressive disorder. However by 6 months there was a significant difference and only nine women in the PBDU group fulfilled RDC for a depressive disorder (two major, seven minor) compared with 23 (16 major, seven minor) women in the RPC group ($p < 0.01$).
All 60 women completed the users’ views questionnaire. The quantitative data were analysed using the chi-square test. It was necessary to recode the responses as ‘satisfied’ and ‘dissatisfied’, ‘helpful’ and ‘unhelpful’ to prevent many of the cells in the contingency tables having fewer than the required five cases. Results are summarized in Table 2 and below.

**Satisfaction with treatment and information received**

The results showed that there was no difference in the women’s satisfaction with the treatment that they had received from their GPs ($p=0.78$) and health visitors ($p=0.55$) and this was reflected in the qualitative data:

> I had lots of help and encouragement ... If it wasn’t for the help and support of my GP, nurses, health visitor, I don’t know where I would be today, if I was here. (RPC3)

The questionnaire data compared the level of satisfaction with overall treatment between the women in the PBDU group and the women in the RPC group. Twenty eight women in the PBDU group felt satisfied with their overall treatment whereas only 13 women in the RPC group felt satisfied ($p=0.04$).

The women were also asked to indicate if they would like to receive the same treatment again. Twenty seven (90%) women in the PBDU group said that they would like the same treatment again compared to only 12 (40%) women in the RPC group.

<table>
<thead>
<tr>
<th>Variable</th>
<th>PBDU ($N=30$) Mean (SD)</th>
<th>RPC ($N=30$)</th>
<th>$p$-value</th>
<th>$t$-test</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerical</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age of woman (years)</td>
<td>28.4 (4.5)</td>
<td>26.9 (5)</td>
<td>0.21</td>
<td></td>
</tr>
<tr>
<td>Age of baby (weeks)</td>
<td>12.0 (12)</td>
<td>10.4 (10)</td>
<td>0.21</td>
<td></td>
</tr>
<tr>
<td>Birth weight (grams)</td>
<td>3,377 (436)</td>
<td>3,363 (535)</td>
<td>0.91</td>
<td></td>
</tr>
<tr>
<td><strong>Categorical</strong></td>
<td></td>
<td></td>
<td></td>
<td>$\chi^2$</td>
</tr>
<tr>
<td>Marital status</td>
<td>Frequency (%)</td>
<td></td>
<td></td>
<td>1.00</td>
</tr>
<tr>
<td>Married/cohabiting</td>
<td>26 (87%)</td>
<td>26 (87%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>4 (13%)</td>
<td>4 (13%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social class*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>7 (23%)</td>
<td>4 (14%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>III</td>
<td>18 (60%)</td>
<td>21 (72%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV</td>
<td>5 (17%)</td>
<td>4 (14%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parity</td>
<td></td>
<td></td>
<td></td>
<td>1.00</td>
</tr>
<tr>
<td>Primiparous</td>
<td>16 (53%)</td>
<td>9 (30%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiparous</td>
<td>14 (47%)</td>
<td>21 (70%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Method of delivery</td>
<td></td>
<td></td>
<td></td>
<td>1.00</td>
</tr>
<tr>
<td>Vaginal</td>
<td>26 (87%)</td>
<td>26 (87%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caesarean</td>
<td>4 (13%)</td>
<td>4 (13%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric history</td>
<td></td>
<td></td>
<td></td>
<td>0.83</td>
</tr>
<tr>
<td>Previous psychiatric history</td>
<td>10 (33%)</td>
<td>10 (33%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous postnatal depression</td>
<td>6 (20%)</td>
<td>7 (23%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*There were no women in social class V or I. One woman in the RPC group was inadequately described.
The comments written by the women help to interpret the Likert-type satisfaction responses. This provides an insight into which aspects of the services were deemed important and why women were more satisfied with the PBDU service than RPC:

Found the staff helpful. They enabled me to feel normal. The support of being able to visit Charles Street was invaluable. (PBDU1)

The PBDU is ‘Very specialized in helping clients to come to terms with various problems and understanding why they are feeling the way they are’ (PBDU11).

Twenty eight (93%) women in the PBDU group said they would recommend the treatments they had received to a friend, compared to only 13 (43%) women in the RPC group (\(p<0.001\)). The comments written by the women were revealing.

Yes, without the help of Charles Street I don’t know where I’d have ended up, so I would definitely send someone to seek advice. (PBDU30)

The support of being able to visit Charles Street was invaluable. (PBDU1)

Despite the positive comments that were written about the PBDU service, three of the women in the PBDU group felt that they would not like to receive the same service in future:

No, I do not feel that the open space did anything for my problems … did not help me. (PBDU4)

I would like to be able to deal with it myself … It’s a very good service, but it’s not for me. (PBDU27)

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**Table 2. Comparison of scores on the Patient Satisfaction Questionnaire for the women in the Parent & Baby Day Unit group and the Routine Primary Care group at 6 months.**

<table>
<thead>
<tr>
<th></th>
<th>Parent &amp; Baby Day Unit (N=30)</th>
<th>Routine Primary Care (N=30)</th>
<th>(p)-value (\chi^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>How satisfied are you with the health services you received after the birth of your baby?</td>
<td>23 (76%)</td>
<td>25 (83%)</td>
<td>0.92</td>
</tr>
<tr>
<td>How satisfied are you with the treatment for postnatal depression you received from your GP?</td>
<td>20 (66%)</td>
<td>20 (66%)</td>
<td>0.78</td>
</tr>
<tr>
<td>How satisfied are you with the treatment for postnatal depression you received from your health visitor?</td>
<td>24 (80%)</td>
<td>25 (83%)</td>
<td>0.55</td>
</tr>
<tr>
<td>How satisfied are you with the health services you have received for your postnatal depression?</td>
<td>28 (93%)</td>
<td>22 (73%)</td>
<td>0.04*</td>
</tr>
<tr>
<td>How much did you know about postnatal depression before you had it?</td>
<td>12 (40%)</td>
<td>7 (23%)</td>
<td>0.54</td>
</tr>
<tr>
<td>How informed are you about postnatal depression now?</td>
<td>30 (100%)</td>
<td>15 (50%)</td>
<td>0.03*</td>
</tr>
<tr>
<td>If you had postnatal depression again, would you like the same treatments?</td>
<td>27 (90%)</td>
<td>12 (40%)</td>
<td>&lt;0.001**</td>
</tr>
<tr>
<td>Would you recommend the treatments you have had to a friend with postnatal depression?</td>
<td>28 (93%)</td>
<td>13 (43%)</td>
<td>&lt;0.001**</td>
</tr>
</tbody>
</table>

*Significant at the 5% level; **significant at the 1% level.
The picture that emerged for the RPC group was very different and while 13 women would recommend treatment to a friend and made comments such as:

Seeing a CPN has been very useful. To be able to talk to someone outside the family is very important. I would recommend it. (RPC23)

Seventeen women in the RPC group would not recommend the treatment they had received:

Couldn’t talk to nurse at doctors. She was useless, didn’t chat, just asked questions. (RPC15)

Doctors and health visitors need to actually ask ‘How are you’ rather than just assuming. (RPC26)

Four of the women in the RPC group highlighted a lack of consultation time as unsatisfactory:

GP's to be more helpful with you. Instead of them giving five minutes of their time we need more time. (RPC20)

Seven women in the RPC group suggested that they would like better follow-up care from health professionals:

More care and better follow-up care from GP, midwife and health visitors. (RPC26)

I have struggled back to recovery on my own. Without tablets and without the help of my husband and family willing me on I don’t know where I would be. There has been no follow-up from my doctor to see if I am fully over my postnatal depression, or if there was any more he, or anyone else could do. (RPC28)

Twelve women in the PBDU group felt ‘very informed’ about postnatal depression prior to treatment compared to seven women in the RPC group \((p = 0.54)\). However, after receiving treatment, all 30 women in the PDBU reported that they felt ‘very informed’ about postnatal depression compared to only 15 women in the RPC group \((p = 0.03)\). These findings were supported by the comments written by the women:

They (PBDU staff) made me feel better about my postnatal depression because of them I fully understood what it was. (PBDU8)

Fifteen women in the RPC group felt ‘very informed’ about postnatal depression post treatment, but may have gained their information from questioning the researcher rather than through their routine care:

The researcher was extremely helpful and told me a great deal. (RPC26)

Fifteen women in the RPC group felt that more information on postnatal depression was needed and the antenatal period would appear to be an acceptable time for the provision of this information:
More information given to pregnant women before they have their babies so that they know it may happen to them. More articles about it in magazines and on TV and radio … All of the medical staff and the office staff should be fully informed of what postnatal depression is and the services and treatments available. (RPC4)

General lack of knowledge and literature about postnatal depression, more information during pregnancy would be useful. (RPC21)

Peer support
The value of peer support was highlighted by one woman in the PBDU group:

Yes, you don’t feel like the only one going through this which meant a lot to me. Talking to other sufferers and counsellors has been the most beneficial treatment I received. It has been important for me to feel that I was not alone. (PBDU6)

Three women in the RPC group reiterated their need for peer contact and support:

I needed someone to talk to about the way I have been feeling. I would like to meet other mums who are going through the same thing. (RPC11)

The research project itself had an important therapeutic impact on women in the RPC group:

I didn’t have any treatment, only the research. (RPC11)

The research has been important for me to feel that I was not alone and completely mad. (RPC8)

This unprompted positive evaluation of the research might reflect that as far as some women were concerned the researcher contact was the only treatment they had received. This further highlights the need for supportive services for women suffering with postnatal depression:

I could never have coped alone. I needed to see and be with people who knew and understood what I was going through. (PBDU34)

Someone to listen and help, to take worries away. A doctor who will listen to problems and has time for you. People who care. Yes, without their help I don’t know where I’d have ended up. (PBDU30)

Discussion
This small pilot study yielded some interesting findings. Women in both groups received GP and health visitor care and there was no significant difference in satisfaction with the treatment received from GPs or health visitors. Analysis showed no evidence of a significant difference between the number of contacts with GPs or health visitors in the PBDU and RPC groups. The qualitative data did suggest that women receiving routine care would prefer a longer consultation with their GP. It may
be that receiving care within a specialist unit results in women receiving a consultation focused on their mental health and this is perceived as more satisfactory than a general consultation.

Whilst there is no significant difference between the two groups in terms of their satisfaction with treatment by GPs and health visitors, it is important to note that nearly one third of the women were not satisfied with treatment by their GP and one fifth were not satisfied with treatment by their health visitor. The PBDU service is a relatively unique service, and most women diagnosed with PND throughout the UK will receive RPC. As such, the finding that one third of women are not satisfied with the treatment provided by their GP, and one fifth are not satisfied with treatment by their health visitor is very important. Although written comments in this pilot study provided some insight into the satisfaction data provided by the Likert-type scales, it would be useful for future research to interview women to explore this dissatisfaction with routine care. In the absence of specialist services for PND, training GPs and health visitors in effective communication should improve women’s satisfaction with routine primary care. Previous research has demonstrated that the shortage of time during general practitioner consultation is problematic (Morrell et al., 1986), but training in effective communication could enhance understanding despite time limitations (Ley, 1990). Good communication between doctor and patient is an essential constituent of care and when the quality of communication is rated highly, patients are more likely to be satisfied (Bertakis, 1977). Patient satisfaction leads to greater adherence to the doctor’s advice and commitment to prescribed treatment plans (Kincey et al., 1975). The role of services in the provision of information is crucial. Carr-Hill (1992) found the most frequent source of patient dissatisfaction to be communication and information about condition and treatment. In this study, 15 of the 30 women receiving routine care described a need for further information about PND. The link between knowledge about PND and increased satisfaction with care pinpoints this as an area of concern for primary care professionals caring for women with PND. Training in PND detection (such as the distance learning course ‘The Emotional Effects of Childbirth’ offered by the Marce® society) does incorporate information about effective communication and support provision and proves successful in helping health visitors to detect and manage cases of PND. Brief training programmes for healthcare professionals which include diagnostic and counselling skills have been shown to improve the care and emotional health of women postnatally, when they form part of routine care (Chambers et al., 2001). Future research is necessary to evaluate the impact of such courses on primary care staff (including health visitors, community midwives and GPs) and the treatment of PND. Indeed, preliminary work conducted by Gerrard et al. (1993) demonstrated that health visitors trained in listening skills could have a positive impact on women, decreasing their symptoms of depression. The adoption of a ‘partnership’ approach as suggested by the Mental Health Recovery Network for Mental Health (University of Central England, Birmingham, 2001) may be an important subject for future research. This approach suggests a focus on the education of both user and professional, designed to promote empowerment alongside the establishment of a community support recovery orientated network, thus fulfilling the communication and support needs described by women receiving routine primary care for PND.

One of the benefits of the PBDU was found to be the availability of peer support. Reviews of the research have shown that depression itself is associated with deficiencies in the quality or quantity of social support (Brugha, 1989, 1995). A
pilot study by Taylor and colleagues (1994) emphasized the extent to which women lack help for postnatal depression and Pitt (1968) suggested that women with postnatal depression frequently report that they are alone with their problems. In a qualitative study of 18 mothers with postnatal depression, Mauthner (1995) discussed the isolation felt by mothers with postnatal depression who had met other mothers without postnatal depression. She noted that mothers’ encounters with other mothers was the yardstick against which they assessed their behaviour and feelings, and pointed to the value of depressed mothers talking to other depressed mothers who have a deep personal understanding of their feelings. O’Connor (1991) found that women who lack a confiding relationship with another woman are as likely to experience psychological problems as those who lack a confiding relationship with their husband (O’Connor, 1991). In the present study the need to have someone to talk to, especially other mothers with postnatal depression, was emphasized. Future work would benefit from examining whether the intensified, individual treatment in the PBDU is valuable in the absence of the peer support available.

Women described the support that they gained from making contact with other mothers within the PBDU. Research has explored the role of social contacts between mothers in both the prevention and alleviation of postnatal depression, and the success of these groups was attributed to the fact that they enabled women to express ambivalent and negative feelings (Elliott et al., 1988). Despite this, Fleming and colleagues (1992) found that their social support intervention was ineffective in reducing depressive symptoms, and Stamp and colleagues (1995) found that their antenatal and postnatal support groups failed to reduce postnatal depression. However, there are methodological problems with these studies which question the reliability of their findings. Certainly this pilot study suggests that women found attendance at the PBDU enabled them to make social contacts that were deemed to be supportive and helpful. It would be useful for future research to focus on the helpfulness of peer support and support groups during the antenatal and postnatal period to see whether this support can reduce postnatal depression in the absence of any other treatment intervention.

The PBDU represents a pioneering approach to the treatment of PND which may serve as a model both nationally and internationally. However, health care providers need to consider carefully the implications of replicating a service such as the PBDU, in light of the facilities, resources and services that are available to them. For example, establishing a Stroke Unit may reduce costs by improving organization and make more efficient use of existing resources. However, unlike stroke patients, who are already being managed in the acute sector, women with PND, if identified, are mainly treated in the community. Hence, establishing units like the PBDU would incur non-recurrent start up costs, such as buildings, staff recruitment and staff training and require ongoing resources for staffing, equipment and facilities. Thus, in the current economic climate, it is unlikely that investment will be made in establishing units like the PBDU. Despite evidence of cost-effectiveness (Boath et al., 2003), it seems more likely that additional support will in future be offered within primary care.

There are some limitations to this small pilot study that need to be discussed. The satisfaction questionnaire was administered as part of a wider study of the cost-effectiveness of alternative approaches to the treatment of PND. The sample size was therefore based on a measure of clinical outcome rather than a measure of patient satisfaction. There are also some difficulties with evaluating retrospective satisfaction data. The user views questionnaire was given to the women at their 6-month research
assessment. Twenty five women in the PBDU group had been discharged from the PBDU by that time and this may have affected their recall. The five women who were still attending the unit may have found it ‘difficult to formally express dissatisfaction in the face of significant caring’ (Nguyen et al., 1983). Indeed, one of the problems in using satisfaction data is the high rate of reported satisfaction (Denner & Halperin, 1974), and the mental health literature is replete with a ‘preponderance of positive responses’ (Frank et al., 1977). Satisfaction itself is likely to be defined differently by different people and by the same person at different times (Locker & Dunt, 1978). To counter methodological difficulties such as these, quantitative and qualitative methods were used to check the reliability of the results and pinpoint inconsistency. An open-ended questionnaire was used instead of semi-structured interviews to encourage any expressions of dissatisfaction, and three women in the study did express dissatisfaction with the PBDU service.

It can be seen from this study that user views can inform research about training and future research needs. It is important that work looking at satisfaction with services designed to fulfil mental health needs consider fully the role of the user.

References


