Family dynamics of postnatally depressed mothers – discrepancy between expectations and reality

Tarja Tammentie MNSc
Doctoral Student, Department of Nursing Science, University of Tampere, Tampere, Finland

Eija Paavilainen PhD
Acting Professor, Department of Nursing Science, Etela-Pohjanmaa Hospital District, Finland

Päivi Åstedt-Kurki PhD
Professor, Department Head Department of Nursing Science, Tampere University Hospital, Research Unit, Tampere, Finland

Marja-Terttu Tarkka PhD
Assistant Professor, Department of Nursing Science, University of Tampere, Tampere, Finland

Background. The birth of a new family member always brings changes to family dynamics. The family has to adjust to a new situation and, although the time after childbirth is happy for most families, postnatal depression affects 10–15% of mothers annually.

Aims and objectives. The purpose of this study was to ascertain families’ experiences of family dynamics when the mother suffers from postnatal depression.

Design. Nine families (nine mothers, five fathers) where the mother had displayed symptoms of postnatal depression took part for the study.

Methods. Data were collected through interviews with nine families where the mother had scored 13 or more on the Edinburgh Postnatal Depression Scale, completed 6–8 weeks after childbirth. Families were offered the opportunity to volunteer for the interview while taking part in a follow-up study of postnatal depression in Finland. Interviews were analysed using the principles of grounded theory.

Results. The findings showed that there was great discrepancy between expectations and reality in the depressed mothers’ families. Parents, especially mothers, strove for perfection, perceived the infant to tie them down and had high expectations of family life.

Conclusions. Everyday family life and human relationships change, the depression and the parents’ attitudes towards the infant manifest themselves in different ways, and support is of great importance.

Relevance to clinical practice. Women, especially those expecting their first child need a great deal of information about mood changes after childbirth and the opportunity to discuss the changes brought about by the birth of a child.

Key words: family, family nursing, grounded theory, postnatal depression
Background

Pregnancy and the birth of a child bring strong psychological, physical and social changes to a woman’s life. Growth into parenthood starts before the child’s birth, during pregnancy. The couple’s relationship goes through a change as they have to redefine their roles in society and in their relationship. It has been shown that a good relationship is the most important resource for managing change (Ruoppila, 1989; Tarkka et al., 1999).

The child’s father is usually the primary source of support for the mother. The greater the father’s involvement in childcare, the easier it is for the woman to become a mother and adapt to the changes caused by the birth of a child (Minuchin, 1974; Ruoppila, 1989). After childbirth, mothers need a great deal of support from their partners, from their own mothers and from the immediate environment (Tarkka et al., 1999; Tarkka et al., 2000). The father’s life is also affected by the birth of a child and growth into fatherhood is not necessarily easy and quick (Kaila-Behm & Vehviläinen-Julkunen, 1999).

The birth of a child alters the spousal relationship either by making it stronger or weaker. A positive experience of pregnancy and the arrival of a new child usually strengthens the couple’s relationship (Belsky & Rovine, 1990). A positive childbirth experience also facilitates adaptation to the new life situation (Wikander & Theorell, 1997).

Postnatal depression affects 10–15% of mothers (Cox et al., 1993; Lane et al., 1997; Walther, 1997). Symptoms of depression include anxiety, weepiness and hopelessness and panic attacks. Feelings of failure as a mother are common and mothers may have difficulty coping with their daily tasks. It is, nevertheless, difficult for mothers to admit their depression even to the partner, and they do not know where else to seek help (Nahas et al., 1999).

Research has shown that men are also affected by postnatal depression. While it is typical that mothers develop depression a few months after childbirth, fathers’ depression starts 4–12 months afterwards. Fathers’ depression is associated with earlier episodes of depression and the spouse’s concurrent depression (Areias et al., 1996a,b). A mother’s postnatal depression induces feelings of helplessness and frustration in the spouse and he may feel that he is incapable of supporting his partner. Feelings of anger may also emerge and the partners may grow apart (Holden & Cox, 1994; Meighan et al., 1999).

The reasons for postnatal depression in women are unclear. Lack of social support and especially an unsatisfactory spousal relationship have been indicated as a common factor. The partner’s presence and practical support help mothers adapt to their new role (Katz & Beach, 1993; George, 1996; Terry et al., 1996; Stuchbery et al., 1998; Cooper et al., 1999; Nahas et al., 1999; Seguin et al., 1999). However, further knowledge is needed to understand better in what kind of situation mothers and fathers live after childbirth. Especially, knowledge convincing families’ experiences of family dynamics are needed to add understanding and develop care of families.

Methods

Purpose

The purpose of this study was to ascertain families’ experiences of family dynamics when the mother suffers from postnatal depression.

Design

Grounded theory is a suitable approach in research areas with little existing theory and when attempting to conceptualize behaviour in complex situations or to understand unresolved social problems (Chenitz & Swason, 1986).

The two main schools of thought in the grounded theory approach, namely the Glaserian and the Straussian (Stern, 1994), differ in terms of approach. The Glaserian approach is inductive (Glaser, 1992) while the Straussian approach is inductive-deductive in nature (Strauss & Corbin, 1994). As the main study of mothers’ postnatal depression started as a quantitative study, the investigator was extensively familiar with the earlier literature, and it was not possible to apply a purely inductive approach for investigating family interaction of postnatally depressed mothers. The research problems were predetermined, although loosely formulated and focused during the course of the research process. Based on these points, we chose the Straussian grounded theory approach.

Sample

Data were collected through interviews with nine families where the mother had scored 13 or more on the Edinburgh Postnatal Depression Scale (EPDS), completed 6–8 weeks after childbirth and who expressed their willingness to tell about their family life after childbirth. The families lived in the Pirkanmaa region, southern Finland, and had a child between October 1998 and February 1999. Families were offered the opportunity to volunteer for the interview while taking part in a follow-up study of postnatal depression and family dynamics in Finland. Thirteen families expressed their
willingness to participate in interviews, but only nine were interviewed, because four could not be contacted despite several attempts by the researchers.

Nine mothers, five fathers and one child took part in the interviews. Two mothers had divorced during the past year, while two others did not want their spouses to participate in the interview. Both parents participated in five interviews and they were interviewed together. In addition, the 9-year-old son of one family participated in the interview.

Of the families interviewed, five had one child, three had two children and one had three children. The mothers and fathers ranged in age from 22 to 35 and from 27 to 45 years, respectively.

Data collection
The study used open-ended interviews in which the families were asked to describe the period during pregnancy and after childbirth in their family. The study did not use predetermined interview themes as the aim was to elicit issues considered important by families. Additional or probing questions were asked depending on the topics that emerged during the interviews or what had been learnt in previous interviews. Interviewees chose the interview setting and all interviews were conducted in their homes. Children were present in all but one interview. All interviews were conducted by the same person and were tape recorded and transcribed by the investigator (TT). Interviews lasted between 40 and 90 minutes and yielded 191 pages of text with single line spacing.

Ethical considerations
Permission to conduct the study was obtained from the ethics committee of the university hospital. Families were offered the opportunity to indicate their willingness to participate and they indicated this by providing their contact information on the EPDS-questionnaire which was used in the first stage of the study (Tammentie et al., 2002). The families had the opportunity to acquire further information about the study from the investigator, whose contact information was attached to the covering letter. The letter explained the purpose of the study, use of the findings and also the names and numbers of all investigators if they want to discuss about the study or their own feelings. All families who took part in the study visit the child welfare clinic regularly where they could have support if they became upset or distressed by the interviews. They could also telephone the investigator for this.

The interviews, the transcription and the analysis were conducted by the same investigator. The findings have been aggregated to make it impossible to identify individual respondents. The selection of the excerpts served the same purpose.

Analysis
The constant comparative method of grounded theory was used for data analysis (Glaser & Strauss, 1967; Glaser, 1978; Chenitz & Swason, 1986; Strauss & Corbin, 1990; Polit & Hungler, 1991). The data were analysed as they were collected. The investigator first listened to the tapes and reviewed the transcribed text to make sure that all data were transcribed. The analysis continued by reading the text and marking all expressions (words and sentences) with substantive codes in each interview’s margins. The substantive codes were then grouped into preliminary categories according to similarity. The preliminary categories included the effects of the birth on the family, expressions related to depression, the effects of depression on human relationships and importance of support.

The preliminary categories were re-reviewed one at a time while searching for subcategories. In this stage of axial coding (Corbin, 1986a,b; Strauss & Corbin, 1990), the categories were examined one at a time and attention was paid to interaction while seeking relevant data. The investigator turned to the original data to check connections between different situations. Memos made during the interview and analysis served to facilitate analysis. Relevant issues were then coded to form concepts, after which concepts with similar content were divided into categories. The category with which all the other categories were associated emerged as the core category. Each category, its features and relationships between categories were compared with the core category (selective coding). The progress of the analysis is shown in Fig. 1.

Findings
Change in everyday family life
Strong reactions to the change in the family system were characteristic of families of postnatally depressed mothers. The birth of a child changed the existing family structure and elicited strong reactions from those involved. Parents perceived the infant to be demanding and their energy was drained by childcare. They felt they are on round-the-clock duty and they observed the infant and its reactions constantly. A constant state of alertness drained them physically and deprived them of the opportunity to spend time together as the infant was the centre of life. Parents suffered from
feelings of inadequacy, and the infant seemed to have infinite needs. Parents felt they were incapable of fulfilling the infant’s needs. They were caught in the cycle of fatigue, and the father tried to help the mother when at home but found it difficult because work took up most of his time. The father had feelings of inadequacy and exhaustion. The mother was tired after childbirth and it seemed that the infant was in constant need of something. One of the mothers described her family situation as follows:

We never had time to have a cup of tea together, I was so tied down to the baby, we couldn’t even go to the sauna together, or separately, for that matter, with the baby always demanding something. You told yourself you won’t have time to eat now and then you’d go through the day without eating and when he’d come home I’d burst into tears saying, ‘Please let me go to the bathroom and have a bite to eat’. I felt he was never home, but I still wanted to manage on my own, although I’d occasionally despair. I was alone with the new baby, not knowing what to do and how. I felt she never stopped crying and that there was no end to her needs. (Mother 1)

Having no time for oneself came as a surprise, although the mother had prepared for it. The fact that partners had no time for each other was considered hard and it took some time to get adjusted to this. Especially, mothers did not want to leave the infant in the hands of strangers to take part in their hobbies, and fathers gradually dropped their hobbies out of an obligation to stay home as the partner could not have any hobbies. Families gradually spent more and more time at home and felt distressed, and the infant was easily blamed for not having time for oneself. The home felt like a prison and the postman’s visit was the highpoint of the day. Parents described that situation as follows:

Both spouses should have resource to their own hobbies. And when the wife had nothing, it was impossible for me to go, I felt obliged to stay at home... (Father 3)

I felt I had no life outside the home and I would watch people going about their business and I was stuck home. You just feel you have to get out but you can’t. (Mother 7)

Life routines changed with the birth of a child, and the responsibility for the infant changed the way parents see everyday issues. The infant’s lack of rhythm distressed parents and everything had to be planned according to the infant’s needs. The infant’s lack of rhythm also caused distress and exhausted the parents. They felt they had lost control over their lives; their daily life was out of hand and life seemed unstable. One mother described this:

I phoned the child welfare clinic asking whether the baby should have a regular rhythm, are they supposed to eat every four hours or what. I felt I had to achieve that rhythm and tried to count the hours and meanwhile he would cry for two hours. And when he woke up after

---

**Figure 1** The progress of the analysis.
two hours instead of four I would be panic-stricken. This is never going to work, there’s no balance in my life. (Mother 7)

Change in family relationships

The birth of a child and related life changes brought about marital discord. Unsettled conflicts tended to resurface and unspoken expectations resulted in conflict. Thoughts and emotions which would have been remained unaddressed had the child not been born were brought to the surface. One partner may tend to withdraw into muteness, and the other may try to address the situation even by picking a quarrel. Parents said:

I could squeeze nothing out of her, I had to use stronger and stronger ways to make her react. I dug deeper and deeper and longed for her to say I am a total shithead, I must have done her wrong over the years, but she never said anything. (Father 3)

Well the fact that the baby is real to the father only after birth might have added to the pain caused by cheating, it was such as heavy burden that she could not keep it in. (Mother 8)

The birth of a child may lead to spousal estrangement. The partners did not necessarily pay enough attention to each other and were jealous of each other’s use of time. Fathers felt like onlookers, excluded from the mother–child dyad. The mother envied the father’s chance to leave the house, go to work and meet other people. Parents’ fatigue and lack of time together resulted in arguments. Silence aggravated the situation and resulted in misunderstanding. The mother felt that she was solely responsible for the infant, while the father was always working. The father started to avoid coming home because of the oppressive situation, and the mother felt that he did not understand her or the infant. The mother’s depression may gradually be transmitted to her partner. Parents described this as follows:

I told him, you being such a wise and understanding person, you just don’t get it, now that you are in it up to your neck... (Mother 8)

The depression is not just the woman’s business, it transmits to the man. I tried to pretend I can manage it, I just need to accept it, and that made me depressed too. It sickens you and you try to cope with it, saying to yourself, ‘Everything’s OK, it will be OK’, and this will just make it worse, looking unimportant in your wife’s eyes. (Father 3)

Change in family life may result in such a deep discord between the partners that separation is seen as the best solution. The child may keep the couple together for a while, but ultimately they did not want to continue the difficult relationship, not even for the sake of the child. Separation was the result of a deadlocked situation, where the partners were incapable of discussing the situation or explaining their views to each other. Thoughts of separation easily surfaced when a mother got depressed after childbirth because of the deadlocked situation. The birth of a child distressed the man to the extent that he was unable to deal with it and felt it easier to get out. Unsettled conflicts before pregnancy and childbirth reached serious proportions and separation was seen as the only way out. One mother said:

He had been such a loving person and then after the childbirth he said he would never have another child with me and he never explained why. He did not move out at that time, I meant to kick him out but then I thought it would be unfair not to give him a second chance. We spent another year together, but it was terribly hard. It got worse and worse, and he thought I was a lazy and poor mother and then I kicked him out thinking it will never change. (Mother 4)

The birth of a child also caused changes in close relationships. The couple’s attitudes towards their own parents changed and new parents tended to compare themselves and their partners with their own parents. Parents made unconscious comparisons between their childhood images and reality. Mothers felt inferior when comparing themselves with their mothers and with their recollections of how their mothers cared for children. Fathers carried with them an image of their mothers as omnipotent and tireless and compared their spouse with this image. Mothers competed with their own mothers whereas fathers compared their image of their partners with their mothers. Families with young children competed by comparing the children’s level of development which prevented them from sharing their problems related to he infant. One father said:

Men leave their childhood home with the illusion that women go around with a baby under each arm, making porridge with her mouth while swapping the floor with her feet. That’s their image of a mother, she is capable of everything and does all the work. (Father 1)

Manifestations of depression symptoms

Mothers’ postnatal depression manifested itself in psychological and physical symptoms, in relation to the environment, in fear of loss, in experiencing closeness as distressing and in striving for perfection. Physical symptoms included sleep disorders, lack of appetite, trembling and heart palpitations. Sleep disorders involved difficulty falling asleep, frequent waking during the night or constant fatigue. The mother lost her appetite and even experienced inability to eat. Trembling in the limbs and the whole body occurred, and palpitations...
were common. One mother described her physical symptoms in this way:

I lost a terrible amount of weight during that time, I weighed less than I did before the pregnancy, I couldn’t eat a thing and couldn’t sleep without pills and I was shaking all the time. I could not sleep more than three or four hours after childbirth, I was unable to write a line and then I started to have palpitations and the only thing I wanted to do was to go to bed and stay there. (Mother 7)

Psychological symptoms involved nervousness and tension, even to the extent of developing panic disorder. Mothers experienced fear and insecurity, especially in relation to their capability as a mother. They had violent mood swings, and experienced feelings of loneliness, restlessness and failure. Feelings of guilt were commonplace and the mother might be angry at the fact that the time after childbirth was not what she thought it would be. Feelings of insignificance might have driven her to the brink of stagnation and exhaustion. However, denial of the situation was common and the mother tried to go on with her life as before and at least provide good physical care to the infant. If the depression was prolonged, she might have lost track of time and experienced unreal feelings:

It was an unreal feeling, it was impossible for me to talk to other people, I was engulfed with my anxiety. (Mother 7)

Families found it difficult to admit to depression and they would have rather talked about fatigue caused by a wakeful infant. Physical fatigue might have been easier to admit to than depression. Families tended to conceal and deny their problems. Depression was regarded as a mental illness demonstrating weakness and therefore as unacceptable. However, it was difficult to identify the depression, because the situation developed slowly and might have been transmitted from the mother to her spouse. One mother described the situation as follows:

Neither of us identified it as postnatal depression, with him being so close to me. Perhaps I would not even have admitted to it, I saw it as a weakness... I’m not crazy, anyway. (Mother 3)

The mother’s attitude towards the environment changed as she got depressed. The depression made her withdraw from social contacts, and she saw the environment as oppressive and was fearful of the infant getting hurt. She started to avoid other people as she felt that nobody would understand her. Meeting with other mothers was also difficult because a depressed mother saw others as successes and good mothers, which made her situation even harder to bear. One described environmental threats in the following way:

My reactions were extremely aggressive… all I could see were threats.

If I saw a dog running loose I’d come close to attacking the owner. All I could see was a threat to my baby. (Mother 2)

Parents’ attitude toward their infant

The mother might have seen the infant as something superfluous. The pregnancy might have been unplanned, which may result in a detached relationship with the child, who was seen as an intruder who had deliberately invaded the family. The child’s demanding behaviour distressed the mother to the extent that she started to feel repulsion for the child and did not want it near her. It might feel impossible to be alone would the infant and the mother might blame the infant for her discomfort. The desire to get rid of the infant indicated the mother’s attempt to solve the unsatisfying situation rather than a concrete wish that the infant would cease to exist:

I started to plan how I’d bump off the whole family, in cold blood. I made elaborate plans to kill them all, I had an escape route planned beforehand. I never thought I’d hurt myself, I just wanted them dead, I wanted to get rid of them and take a holiday in the sun. I just wanted out. (Mother 6)

However, the mother experienced a strong fear of losing the infant. She felt it was impossible to let somebody else take care of the infant, not even her partner or the grandparents, as she believed that nobody else was capable enough. She feared that something bad will happen to the child if she so much as glances away, and some of the mothers watched the infant sleep and get up several times during the night to check that the infant was breathing. The infant might share the mother’s bed so that they shall be close at all times. One mother described the fear of losing her infant as follows:

I was pretty hysterical in the beginning, I used to watch her sleep and breathing to see that she was alive. I heard about a family who had found their baby not breathing in bed and they had revived her and she had survived. I was prepared to start reviving her at any time. (Mother 5)

Mothers strive for perfection as mothers. Families of depressed mothers had a clear vision of how they will care for their child. After the child was born, families had to deal with a compulsion to succeed, which manifested itself in denial of problems and in slavish adherence to the guidance provided by the child welfare clinic and childcare manuals. Parents wanted the infant to look beautiful and well-cared for and might exhaust themselves by striving for perfection in childcare. Problems with breastfeeding and the infant’s
sleeping distressed parents and caused indecisiveness. They breastfed the infant, even by force, because the child welfare clinic had strongly emphasized the importance of breastfeeding. As one mother said:

If I had given her some formula as well she could have slept through the night, but I did not realize this because the importance of breastfeeding was overemphasized. I had a phobia of formula, nothing but formula feed as the child welfare clinic kept emphasizing the importance of breast milk. They asked about breastfeeding every time and formula feed was the worst thing that you could do to your child. (Mother 3)

Importance of support

Being tied down to the infant and the infant’s role as the centre of life drove new parents into a situation where they needed urgent support from outside people. Partners also needed support from each other. The mother’s failure to receive support from her partner in the new life situation caused feelings of distress and loneliness in the mother. The father might also feel like an outsider because of the close tie between mother and child, which consequently made it impossible for him to help his partner, although he recognized her need for help. The father might gradually withdraw from the situation into his hobbies and work and leave the infant to the mother, especially if he felt that she did not trust him as a caregiver. However, mothers needed support and encouragement from their partners and saw it as a necessity. The father’s concrete presence was also of great importance to the mother. A family described the situation as follows:

I wouldn’t say I was ignored, but I received less attention… (Father 4)
It was easier with him being at home, but if he had worked it would have been a chaos. (Mother 5)

Concrete support from the partner split the mother’s responsibility for the infant and the infant became the couple’s mutual responsibility. The father’s concrete support in childcare brought the spouses closer together and helped better to understand the emotional turmoil caused by the infant. The lack of concrete support from the father made the mother lonely and alienated. Although the mother might not want to leave the child to the father, his support and assistance with other chores helped the mother and facilitated their closeness in seeing the family as a ‘joint venture’. A father described the tangible support in the following way:

I’ve been involved as much as possible, we have never thought this is my job and this is yours, we have both done as much we could, I mean if the wife is tired in the morning, it’s my job to get up and do my bit, with the kids screaming for all sorts of things. And you do want to do your bit. (Father 5)

The importance of grandparents as sources of support is great. However, families often felt that grandparents’ well-meaning recollections of their childcare experiences added to the family’s distress and feelings of guilt and failure. Grandparents’ recollections of their own childhood were positive and made it difficult for parents to talk about their exhaustion. The grandparents’ enthusiasm for the grandchild might make the parents feel as onlookers or as a means to produce grandchildren. If the mother had a close relationship with her own mother before the birth of the child, the grandmother might be the best possible support person. Parents appreciated the grandparents’ presence and tangible help, although they might not have the courage to ask for help in caring for a weepy infant, not wanting to trouble their parents. A mother described the importance of support from her own mother as follows:

It has always been like that. I would visit my mum, it was a chance to discuss and take a break. I could talk to her… We have always been able to talk. She has never imposed her opinions on me. I find it easy to talk about my feelings to my mother. (Mother 8)

Mothers reported that peer groups were an important source of support. Discussions with other mothers helped them see that they are not alone and that other parents struggle with similar problems. Mothers preferred peer groups arranged by the child welfare clinic and the church, because they gave them the chance to meet with other women with a similar life situation, not known to them from before. Discussions with friends, especially if they had children of the same age, could lead to competition and it was impossible to talk about one’s feelings or problems. A mother described the support from the peer group as follows:

I really should have gone right away. They did tell me about it, but when I finally went I thought, ‘How stupid of me, I should have joined a group immediately, it would have been a lot easier’. You get to hear that everybody has the same problems, that we are not the only ones who have failed, mothers talk about their lives and it felt like they were talking about my life. (Mother 3)

Relationships between categories: striving for perfection, being tied down to the infant and expectations of family life

The relationships between the categories were formed by comparing them using theoretical memos. The categories were compared with each other and with the original data. The relationships included the parents’ striving for perfection,
being tied down to the infant and expectations of family life. These relationships enabled the expression of essential connections between the different categories.

Striving for perfection involved both partners. It appeared in relation to other people in that parents wanted to create the image of a happy and resilient family. Instead of talking about their problems, parents tended to depict family bliss. They wanted to be perfect parents who can take care of their children without the help of outside help and advice. They tended to deny their need for support so as not to give the environment an impression of weakness. The impossibility of reaching perfection induced feelings of failure and might result in depression.

Being tied down to the infant put parents in a new situation, where the infant’s needs were at the centre of family life and the intensity of these needs took priority over everything else. The circle of friends changed, grandparents’ attention was focused on the infant and parents had no time for each other. The need for support was great but it was overwhelmed by the desire to manage on one’s own. Parents exhausted themselves by trying to fulfil the infant’s needs and end up depressed.

Expectations of family life were great if the pregnancy was carefully planned to suit the couple’s life situation. However, pregnancy might have been delayed or the woman might miscarry. When the child was born, families’ expectations of happiness and functional family life were great. The infant’s lack of rhythm induced uncertainty in parents, human relationships suffered and the circle of friends changed as parents seek the company of other families with children. The parents’ strong urge to cope prevented them from receiving support or even admitting to their need for support. Failed expectations resulted in feelings of disappointment and failure and eventually in depression.

Core category: discrepancy between expectations and reality

Almost all pregnancies in the study were carefully planned and parents tended to see parenthood as a performance. They had created an image of family life after the child is born, and read a great deal about childcare and formed an image of everyday family life based on this. The messages conveyed by the environment about the life of a family with children were all positive, and parents’ expectations were great. Their need to be perfect parents gradually turned parenthood into a performance where success was the measure of their value as parents and human beings. The situation after the birth of a child was nevertheless new and strange and despite their expectations, parents cannot control the situation. The infant’s lack of rhythm or aches and pains especially distressed parents, with the infant crying although everything should be fine. Being tied down to the infant was perceived to be a difficult thing and parents had difficulty understanding the infant’s non-verbal messages. Family life did not measure up to the parents preconceived fantasies and they felt the situation was slipping out of their control. This might lead to depression and parents might get angry at the situation. A mother described the discrepancy between expectations and reality as follows:

And then I started to get really angry, I thought there must be a design flaw somewhere, the mother’s supposed to feel great after childbirth. I would have wanted to nurse her right from the beginning but was in a terrible state, I couldn’t get out of bed and felt that it was not what I had expected and I was so terribly angry. (Mother 3)

Discussion

Reliability

The reliability of the study was enhanced by ensuring that the results fitted the data and that the course of the study was comprehensible, general and controlled (Glaser & Strauss, 1967; Lowe, 1996).

An endeavour was also made to enhance the reliability of the study by making sure that the researchers were well-acquainted with the topic, by describing the analysis process as precisely as possible and by reporting the results at an abstract and conceptual level, after substantive, axial and selective coding process. This was done to ensure that a deeper conceptual level was reached in the analysis beyond mere description of the data. Examples of the original data provide additional evidence of the analysis based inductively on data (Glaser & Strauss, 1967; Glaser, 1978; Lowe, 1996).

Interpretation of the findings

Parents described the powerful changes in their daily life and lifestyle caused by the child’s birth. The infant was perceived to be demanding and the parents had lost the chance to spend time together. Moreover, as the mean age at which Finnish women give birth is 29 years, most parents had completed their studies and launched a career before the birth of the child. They had established close social ties outside the home. After the birth of the child, the parents and especially the mother felt trapped at home and experienced the threat of losing their sense of identity. The rhythm of life changed and parents felt that they had lost control over their lives.
Clinical nursing related to specific groups

The new situation may give rise to marital conflict. Parents grow tired and may not have the energy to pay attention to the other parent as a spouse. The mother may be jealous of the time the father spends with the infant or the father may feel jealous and left out. The situation may gradually result in spousal estrangement, even separation. The mother’s depression induces feelings of helplessness and frustration in the father. These findings support those reported by Holden & Cox (1994) and Meighan et al. (1999). The mother’s depression may also be transmitted to her spouse, as indicated by Areias et al. (1996a,b).

Mothers reported symptoms of depression such as sleep disorders, loss of appetite, trembling and palpitations. Psychological symptoms included nervousness, tension and the onset of panic disorder. Similar findings have been reported by Bewley (1999). The mother feels insecure about her role as a mother, which may give rise to mood swings and feelings of loneliness and failure. It is, however, impossible to talk about these feelings to others. It is often easier to talk about fatigue, and depressed mothers often blame physical fatigue for their symptoms. These findings are consistent with those reported by Nahas et al. (1999).

A depressed mother tended to avoid going out and may withdraw from social relationships. Going out while depressed might be overwhelming, and the desire to maintain the image of a capable parent in the eyes of others prevented the mother from going out and meeting other people.

The depressed mother’s attitude towards the infant fluctuated strongly. The most common attitudes were over-protectiveness and a strong fear of losing the infant, but mothers also reported feelings on anger and a sense that the infant is an intruder. Mothers felt compelled to succeed as mothers. In a situation like this, mothers need a great deal of support to be able to develop a functional relationship with the infant.

The most important source of support for the mother was her partner. Psychological support from the partner was an important resource especially for a depressed mother. Not only did the partner’s presence and concrete assistance with childcare help mothers cope, but also helped fathers get to know the child and maintain closeness in the spousal relationship. Earlier research (e.g. George, 1996; Cooper et al., 1999; Tarikka et al., 1999, 2000) has also shown the importance of spousal support as a resource for mothers.

Grandparents can also provide valuable support. Occasional assistance with childcare, advice and instructions help parents cope with childcare and prevent postnatal depression. However, parents may take the well-meaning advice given by grandparents as criticism. A depressed mother is in a fragile state of mind and she should be approached with sensitivity.

Peer support was the second most important form of support after spousal support. Meeting with other mothers in the same life situation helped take a detached view of the situation, and the awareness of not being alone helped many families.

Suggestions for nursing practice

Women, especially those expecting their first child, need a great deal of information about mood changes after childbirth. It is difficult to adopt or even receive information during pregnancy, particularly about negative aspects. Nearly all Finnish women and the majority of their partners visit the child welfare clinic regularly, which provides the public health nurse the opportunity to discuss the changes brought about by the birth of a child.

Families have close contact with the child welfare clinic after childbirth. The information given in the child welfare clinic, however, easily focuses on the child and childcare thus brushing aside the wellbeing of the parents. Child welfare clinics should pay more attention to the wellbeing of the family as a whole.

Postnatal depression has been a relatively much studied topic from the perspectives of the mother and the mother–child relationship. More research is needed on the effects of postnatal depression on family relationships, the partner and family functioning.

Contributions

Study design: TT, PÅ-K, M-TT, EP; data analysis: TT; manuscript preparation: EP, PÅ-K; literature review: TT.

References


