

Postnatal depression and the evaluation of an Integrative Parenting Programme

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Summary

Postnatal Depression and the evaluation of an Integrative Parenting Programme

Keywords: Postnatal depression; maternal depression; couples' intervention; programme development; parenting programme

Postnatal depression (PND) is a common mental healthcare problem in the puerperal period. The aetiological factors have been researched extensively and research shows that PND develops due to the complex interaction of biological, psychological and social factors. The quality of the couples' relationship has been identified as an important contributing and maintaining factor, but also a protective factor in the prevention and faster recovery from depressive symptoms. Relationship difficulties and a lack of support are modifiable and could effectively be addressed through therapeutic intervention. Regardless, few parenting programmes focus on the parents as a unit and often excludes the father. This results in the elimination of a valuable and available source of support.

The first aim of this study was to explore couples' experience of maternal postnatal depression in a group of parents in a South African setting. A qualitative approach was used in order to gain a deeper understanding of the nature and impact of PND from the perspective of couples who experience it first-hand. The design of the first research aim was exploratory and descriptive in nature. Purposive sampling was used in the selection of participants. The sample consisted of 13 multiparous couples with an infant younger than twelve months of age. The researcher engaged with couples who experience maternal PND in order to learn from their experience and gain an understanding of this population's unique needs. Data was collected by means of semi-structured interviews and was analysed through thematic data

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analysis. Themes that emerged highlighted a noteworthy physical, psychological and interpersonal impact on all members in the family system.

The second aim was to identify themes by means of an analysis of the literature and from the data obtained through the semi-structured interviews, in order to determine what essential elements need to be included in an integrative parenting programme for parents where the mother suffers from postnatal depression. This was done with the purpose of compiling such a programme. The research design for aim two was interpretive. Through a thorough literature analysis and semi-structured interviews with couples who experience maternal PND, four categories of crucial elements for a programme of this nature was identified namely: support and debriefing; improved knowledge of the condition by means of psycho-education; cognitive restructuring and the acquisition of practical parenting and coping skills.

The third aim entailed the presentation of the integrative parenting programme to a panel of experts with experience in the field of PND. Utilizing the Delphi method, experts were requested to critically evaluate the quality of the structure and content of the programme, with the aim of refining and finalising the proposed programme. The research design for this aim was exploratory, the researcher drew from the wealth of knowledge of experts who actively work with mothers or couples who experience maternal PND. Ten professionals from different mental health disciplines participated in the evaluation and commented on the arrangement, content, methods, strengths, limitations and probable challenges of the suggested programme. These recommendations served as a guide in the enhancement of the integrative parenting programme.

In conclusion, this study offers a new parenting programme for couples who experience maternal PND, that serves to address the following needs: to strengthen the family's support system and to combat isolation; to educate couples about PND; to strengthen

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individual coping resources; to improve the couples' relationship; to increase the parents' sense of self-efficacy regarding the parenting role and to encourage moments of joyful interaction within the family.

Opsomming

Postnatale Depressie en die evaluering van 'n Geïntegreerde Ouerskap Program

Sleutelwoorde: Postnatale depressie; maternale depressive; verhouding intervensie; program ontwikkeling; ouerskap program

Postnatale depressie (PND) is 'n algemene geestesgesondheid probleem na die geboorte van 'n baba. Die etiologiese faktore is wyd nagevors, en navorsing toon dat PND ontwikkel as gevolg van die komplekse interaksie tussen biologiese, psigologiese en sosiale faktore. Die verhouding tussen ouers is bevind as 'n belangrike bydraende en onderhoudende faktor, maar ook 'n beskermende faktor in die voorkoming en spoedige herstel van depressiewe simptome. Verhoudingsprobleme en 'n tekort aan ondersteuning kan effektief gewysig word deur 'n terapeutiese intervensie. Ten spyte hiervan is daar min ouerskap programme wat fokus op die ouerpaar as 'n eenheid. Dikwels betrek programme nie die pa nie, met die gevolg dat 'n waardevolle en beskikbare bron van ondersteuning uitgesluit word.

Die eerste doelwit van hierdie studie was om ouerpare se belewenis van maternale postnatale depressie te ondersoek in 'n groep Suid Afrikaanse ouers. 'n Kwalitatiewe benadering is gevolg om 'n deurgronde begrip te ontwikkel van die aard en die impak van PND vanuit die perspektief van ouers wat dit eerstehands beleef. Die ontwerp van die eerste navorsing doelwit was ondersoekend en beskrywend van aard. Doelgerigte werwing is gebruik om deelnemers vir die studie te selekteer. Die gekose groep het bestaan uit 13 ouers met meer as een kind, waarvan die jongste jonger as twaalf maande oud was. Die navorsers het met ouers ontmoet wat maternale postnatale depressie beleef om uit hulle ervaring te leer en 'n begrip te ontwikkel vir die populasie se unieke behoeftes. Data is ingevorder deur semi-gestruktureerde onderhoude en is geanaliseer deur tematiese data analise. Temas wat uitgelig

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is, dui op 'n beduidende fisiese, psigologiese en interpersoonlike impak op alle lede in die gesinsisteem.

Die tweede doelwit was om temas te identifiseer deur middel van 'n analise van die literatuur, sowel as vanuit die data bekom uit die semi-gestruktureerde onderhoude. Dit is gedoen met die doel om noodsaaklike elemente te bepaal wat in 'n geïntegreerde ouerskapsprogram vir ouers, waar die ma aan postnatale depressie lei, ingesluit behoort te word, met die oogmerk om 'n program van hierdie aard te ontwikkel. Die navorsingsontwerp vir doelwit twee was interpretatief in aard. Deur middel van 'n deeglike data analise en semi-gestruktureerde onderhoude met ouerpare wat maternale postnatale depressie beleef, is vier noodsaaklike elemente vir 'n program van hierdie aard identifiseer, naamlik: ondersteuning, verbeterde kennis van die kondisie deur middel van psigo-opvoeding, kognitiewe herstrukturering en die verkryging van praktiese ouerskap en hanteringsvaardighede

Die derde doelwit was die voorlegging van die program aan kundiges in die veld van PND. Kundiges is versoek om die program krities te evalueer met betrekking tot die struktuur en inhoud van die program. Dit is gedoen deur middel van die Delphi metode, met die doel om die program te verfyn en te finaliseer. Die navorsing ontwerp vir hierdie doelwit was ondersoekend, en die navorsers het kennis geput uit die rykdom van kennis van kundiges wat aktief in die veld werk met moeders en ouerpare wat maternale PND beleef. Tien kundiges vanuit verskillende geestesgesondheid dissiplines het deelgeneem aan die evaluering en het kommentaar gelewer oor die uitleg, inhoud, metodes, sterktes, beperkinge en waarskynlike uitdagings wat die voorgestelde program mag bied. Hierdie aanbevelings was rigtinggewend in die verbetering van die geïntegreerde ouerskap program.

Ten slotte bied hierdie studie 'n nuwe ouerskap program vir ouerpare wat maternale PND beleef, met die doel om die volgende behoeftes aan te spreek: om die familie se

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ondersteuningsnetwerk te versterk en isolering te beveg; om ouers kundig te maak oor PND;
om individuele hanteringsvaardighede te versterk; om die ouerpaar se verhouding te versterk;
om die ouers se sin vir self doeltreffendheid met betrekking tot die ouerskap rol te verhoog;
en om oomblikke van vreugdevolle interaksie binne die familie aan te moedig.

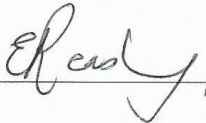
Preface

- The thesis is submitted in article format as described in rules A.14.4.2, and A13.7.3, A13.7.4, A17.7.5 of the North-West University.
- The three manuscripts comprising this thesis will be submitted for review to *Health Care for Women International* (Manuscript 1), the *International Journal of Mental Health Promotion* (Manuscript 2), and *Journal of Contemporary Psychotherapy* (Manuscript 3).
- The referencing style and editorial approach for this thesis is in line with the prescriptions of the *Publication Manual* (sixth edition) of the American Psychological Association (APA). The articles are compiled according to the guidelines of the journals to which the articles are submitted.
- For the purposes of this thesis, the pages of the thesis as a whole are numbered consecutively. However, for submission purposes each individual manuscript will be numbered starting from Page 1.
- Attached please find the letter signed by the co-author authorising the use of these articles for purposes of submission for a PhD degree.

Letter of Permission

Permission is hereby granted for the first author, L. Ferreira, to submit the following document for examination purposes towards the attainment of a PhD degree in Clinical Psychology:

Postnatal Depression and the evaluation of an Integrative Parenting Programme



Prof. E. van Rensburg

Promotor and co-author

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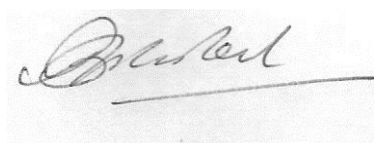
To whom it may concern: Certificate of Editing

This letter serves to confirm that in **November 2016** I did the proofreading and the language editing for the Doctoral Thesis of **LIEZEL FERREIRA**
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I have proofread and edited the entire text of the thesis and the List of References but I have not been asked to edit any Appendices. This editing principally involves proofreading, language, style and grammar editing; and also checking the text for clarity of meaning, sequence of thought and expression and tenses. I have also noted any inconsistencies in thought, style or logic, and any ambiguities or repetitions of words and phrases, and have corrected those errors which creep into all writing. I have written the corrections on the hard copy and have returned the document to the author, who is responsible for inserting these. Please note that this confirmation refers only to editing of work done up to the date of this letter and does not include any changes which the author or the supervisor may make later.



Bernice McNeil
November 2016



Postnatal Depression and the Evaluation of an Integrative Parenting Programme

Section A: Introduction, Rationale, Contextualisation of Postnatal Depression and Research Methodology

1.1 Introduction and problem statement

The time spent waiting for the birth of an infant is normally celebrated with joy and excitement (Wilkinson & Mulcahy, 2010), and new parents eagerly prepare for the welcoming of their little baby. However, having children is one of the most significant life changes a couple will ever experience and the period after childbirth can be extremely overwhelming (Venis & McCloskey, 2007). Life transitions, even when perceived as positive, can be challenging and may generate significant stress (Glavin, 2012; Milgrom, Schembri, Ericksen, Ross, & Gemmill, 2011; Nonacs, 2006; Shapiro & Gottman, 2005; Wang & Chen, 2006). Becoming a parent is a complex experience (Parfitt & Ayres, 2009) that entails both positive and negative change on a psychological and social level (Teixeira, Figueiredo, Conde, Pacheco, & Costa, 2009). During this life phase, there are many demands on parents' coping and problem solving abilities (Rode, 2016). The family adjusts to the birth of a new baby and the change in family dynamic, while the mother is recovering from the physical trauma of childbirth and is experiencing hormonal changes and fluctuations, and both parents are sleep-deprived, exhausted and completely responsible for every aspect of their little baby (Goodman, Guarino, & Prager, 2013; Seymour, Giallo, Cooklin, & Dunning, 2014; Yim, Tanner Stapleton, Guardino, Hahn-Holbrook, & Dunkel Schetter, 2015). In addition parents could be struggling with confusion due to the discrepancy between what they expected to feel and what they are experiencing in reality (Yim et al., 2015).

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Without adequate support, these changes could increase the risk for the development of psychological difficulties (Figueiredo & Conde, 2011). More specifically, the postnatal period is a time of vulnerability for the development of depression (Edhborg, Matthiesen, Lundh, & Widström, 2005; Page & Wilhelm, 2007).

Postnatal depression (PND) is a widespread, possibly life-threatening and disabling major mental healthcare problem in the western world (Grigoriadis & Ravitz, 2007; Kuosmanen, Vuorilehto, Kumpuniemi, & Melartin, 2010) and has a severe impact across diverse cultures in the developing world (Dennis, Janssen, & Singer, 2004). O'Hara and McCabe (2013) report that 13% - 19 % of women experience depression within the first 12 months postpartum. However, Morrissey (2007) states that postnatal depression is significantly under-diagnosed. Recent studies show that the prevalence of postnatal depression in the South African population is very high (16% to 34.7%) (Peltzer & Shikwane, 2011; Ramchandani, Richter, Stein & Norris, 2009).

Symptoms include anxiety, panic attacks, being constantly fearful, tearful, and overly sensitive, uncontrollable temper tantrums, agitation, feeling out of control, lacking confidence, poor self-esteem, lack of sleep/rest, being terrified of being alone, low libido, feeling overwhelmed and exhausted (Morrissey, 2007), low mood, tiredness, lack of energy, forgetfulness, irritability and poor functioning overall (Peltzer & Shikwane, 2011).

PND interferes with self-care, enhances conflict and discontent in intimate and interpersonal relationships (Mulcahy, Reay, Wilkinson, & Owen, 2010; Kane & Garber, 2004), and also makes it difficult to focus on, and respond to, the infant's experience of the world (Emanuel, 2006). This could result in negative long-term effects on a child's emotional and cognitive development (Davè, Petersen, Sherr, & Nazareth, 2010; Huang, Lewin,

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Mitchell, & Zhang, 2012). A parent's depression could thus have serious implications for the health and wellbeing of all members in the family system (Goodman, 2004).

The exact cause of postnatal depression is still being researched (Wiklund, Mohlkert, & Edman, 2010). Researchers are however in agreement that multidimensional factors such as hormonal changes (Melrose, 2010), and also personal and social factors, as well as a history of depression contribute to, and interact in, the development of PND (Morrissey, 2007). Furthermore, the lack of partner support in the perinatal period has been identified as being influential in the development and maintenance of depression (Clatworthy, 2012) and this impacts significantly on the depressed person's ability to cope in the postnatal period (Kathree & Petersen, 2012). Additionally, the quality of the couple's relationship is one of the strongest predictors of PND (Dalfen, 2009; Milgrom, Martin, & Negri, 2006b; Venis & McCloskey, 2007) and preliminary evidence shows the benefit of a relationship-based intervention for PND (Clatworthy, 2012; Page & Wilhelm, 2007). A strong relationship could be a protective factor against the impact of PND on the family and infant and could speed up the recovery process (Dalfen, 2009).

Despite the research evidence, few programmes focus on preparing couples for the challenges they may face after the birth of their infant (Pilkington, Milne, Cairns, & Whelan, 2016; Schulz, Cowan, & Cowan, 2006; Shapiro & Gottman, 2005) or create awareness of the risks of developing PND during this time (Roehrich, 2007).

It is clear that postnatal depression is a serious global problem, with far-reaching implications for the health system and the family system as a whole. Previous studies have advocated for the incorporation of both parents into PND interventions (Paulson & Brazemore, 2010; Mulcahy et al., 2010; Kane & Garber, 2004). As far as the current

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researcher is aware, no other South African study has developed a postnatal programme specifically for couples.

This study makes contributions on three levels and has theoretical, research and therapeutic value. Firstly, on a theoretical level, it elaborates on the knowledge base of postnatal depression with specific focus on the presentation in females, and the role this depression may play in the couple's relationship and the family system. Secondly, it adds value on a research level as it provides information that can be used in the development of more effective postnatal healthcare practices. Thirdly, it adds value on a therapeutic level, by introducing a new integrative parenting programme that has been developed with the aim of addressing issues within the individual, the couple- and the family system that could maintain or exacerbate the PND symptoms. The programme also aids in creating a healthier relationship for intimate partners and helps to create a more nurturing environment for the baby, thus fostering greater opportunities for the development of secure attachment.

The primary aim of this study is to develop an understanding of couples' experience of PND with the purpose of contributing to the advancement of psychological treatment for parents experiencing maternal PND, specifically in the South African context. The thesis takes on an article format and comprises three manuscripts that are presented in succession with author guidelines from each journal. An analysis of the literature provides an overview on existing research regarding the nature of PND and the interventions used in the treatment thereof.

The aim of the study presented in the first manuscript (Section B1) was to explore how couples experience postnatal depression, as it presents in mothers, in a group of parents in a South African setting. A literature analysis and semi-structured interviews with couples who experience maternal PND were done in order to determine the essential elements to be

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included in an integrative parenting programme for parents where the mother suffers from postnatal depression, with the purpose of compiling such a programme.

The aim of the study as presented in the second manuscript (Section B2) was to evaluate the proposed parenting programme by a panel of experts, in order to refine the content and quality of the programme. This was done by applying the Delphi method.

The aim of the study as presented in the third manuscript (Section B3) was to develop an integrative parenting programme for couples who experience maternal PND, based on the two previous studies.

The final section (Section C) comprises of a reflection of the main findings. Implications for clinical practice are indicated and recommendations are made for future research.

1.2 Postnatal depression

Depression is common in the postnatal period (Wiklund et al., 2010) and can also occur in the antenatal period or in both these periods (Becker, Weinberger, Chandy, & Schmukler, 2016; Leigh & Milgrom, 2008). Postnatal depression is defined as a state of enduring sadness or anxiety that persists for longer than two weeks after giving birth, and is marked by acute emotional and psychological distress (Morrissey, 2007). Symptoms are debilitating, do not resolve without intervention, and they interfere with daily functioning (Robertson, Grace, Wallington, & Stewart, 2004; Venis & McCloskey, 2007). The highest risk period for PND to develop is within the first month post childbirth (American Psychiatric Association, 2013; Dalfen, 2009; Venis & McCloskey, 2007), but empirical research has shown this time period to be variable and symptoms could occur hours after birth and extend up to a year after giving birth (Iles, Slade, & Spiby, 2011; O'Hara & McCabe, 2013; O'Hara, 2009; Venis & McCloskey, 2007; Yim et al., 2015). PND occurs not only in women who

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give birth, but also in mothers who adopt or make use of surrogate mothers; and in men (Melrose, 2010).

Although researchers have reported different percentages with regards to the prevalence of PND (Wylie, Hollins Martin, Marland, Martin, & Rankin, 2011), a recent study shows that approximately 15% -19% of new mothers develop PND (O'Hara & McCabe, 2013) and a local study indicates that postnatal depression is a serious problem in the South African population with a prevalence of 34.7% (Peltzer & Shikwane, 2011). In developed countries the prevalence was recorded as being 14.5%, which is considered high (Gaynes et al., 2005). However, PND remain underdiagnosed and undertreated (Becker et al., 2016). Given the anticipated adjustment difficulties, less pronounced symptoms of postnatal depression could often be overlooked, leaving this serious condition untreated (Robertson et al., 2004). New parents might regard their symptoms of depression and anxiety as normal or fear judgement should they seek help; and the stigma attached to mental illness could contribute to under-identifying and diagnosing of PND (Alici-Evcimen & Sudak, 2003).

1.2.1 Diagnosing postnatal depression.

Currently the diagnosis of mental disorders, including postnatal depression (or major depression with postpartum onset) is based on the DSM 5 and ICD10. One of three postnatal conditions is determined by the extent and severity of the symptoms. On the one end of the continuum: postpartum blues, on the opposite side of the continuum, a severe mental illness: postpartum psychosis and, between a normal response to childbirth and a severe pathological disturbance: postnatal depression (Dennis et al., 2004; Glavin, 2012; Page & Wilhelm, 2007; Robertson et al., 2004).

Symptoms vary, presenting in differing degrees (Venis & McCloskey, 2007), and could be divided into *physical*, *cognitive* and *emotional* symptoms (Dalfen, 2009).

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- Physical symptoms could include lack of sleep/rest, exhaustion, lack of energy, changes in appetite, gaining or losing weight, low libido, tremors, somatic symptoms (i.e. constipation, diarrhoea, itchiness, sore muscles, headaches, restlessness, chest pains, heart palpitations and hyperventilation).
- Cognitive symptoms could include forgetfulness, memory loss, poor concentration, poor decision-making, intrusive thoughts, excessive concern for the baby, confusion.
- Emotional symptoms could include dysphoria (low/depressive mood), emotional lability, apathy, loss of interest in activities or people, isolation, having escape fantasies, tearfulness, feeling disconnected, disinterest in the baby, feelings of guilt and shame, anxiety, excessive worries, panic attacks, being constantly fearful and overly sensitive, uncontrollable temper tantrums, agitation, irritability, feeling out of control, lacking confidence, poor self-esteem, feelings of inadequacy, feeling terrified of being alone, feeling overwhelmed, suicidal ideation, fear of harming self or others and poor functioning overall (Dalfen, 2009; Dennis et al., 2004; Dennis & Hodnett, 2009; Dennis & Ross, 2006; Glavin, 2012; Miles, 2011; Morrissey, 2007; Page & Wilhelm, 2007; Peltzer & Shikwane, 2011; Robertson et al., 2004; Seymour et al., 2014; Zauderer, 2008).

There is debate regarding the need for a separate clinical category for postnatal depression as there are researchers who believe that the presentation of postnatal depression does not differ from that of minor or major depressive episodes (Beck & Indman, 2005; Craig, Judd, & Hodgins, 2005; Evans, Heron, Francomb, Oke, & Golding, 2001; Jomeen & Martin, 2008). According to the medical model, depression is caused by a chemical imbalance in the brain (Paulson & Bazemore, 2010) and, like all other forms of depression, PND has a biological component (Nonacs, 2007) and develops under the same psychosocial conditions as depression that occurs at other times (O'Hara & McCabe, 2013; O'Hara, 2009).

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However during this period there is the added stress of a very dependent infant whose needs have to be met (Puckering, McIntosh, Hickey, & Longford, 2010).

Not all women with PND will necessarily fit the diagnosis of major depressive disorder (Milgrom, Ericksen, McCarthy, & Gemmill, 2006a) and depression is often not the first or most important symptom to present in someone with PND (Beck & Indman, 2005). Bernstein et al. (2008) suggest that there are differences between major depressive disorder (MDD) and PND with regards to less pronounced sadness and elevated levels of restlessness and irritability as well as impaired concentration and decision-making in PND sufferers. According to Beck and Indman (2005), the difference between normal depression and postnatal depression includes the significant levels of irritability and anxiety experienced by patients suffering from PND and due to this predominant experience of anxiety, Kleiman (2000) refers to PND as agitated depression.

Meeting the criteria of other clinical categories (minor depressive disorder, adjustment disorder, dysthymic disorder and mixed anxiety-depressive disorder) could also constitute a diagnosis of PND (Matthey, Barnett, Howie, & Kavanagh, 2003). Depression rarely presents without being preceded and accompanied by anxiety. The relationship between these two comorbid diagnoses is bi-directional (Mor & Winqvist, 2002), and the co-occurrence of these two diagnosis could maintain mental illness in postnatal women (De Camps Meschino, Philipp, Israel, & Vigod, 2015). Mor and Winqvist (2002) indicate that patients who are diagnosed with depression have a high probability of a lifetime diagnosis of an anxiety disorder, and women who present with high levels of anxiety seem to have a poorer prognosis (Matthey et al., 2003).

Beck and Indman (2005) expressed concern regarding the use of diagnostic criteria in the Diagnostic and Statistical Manual IV-TR (DSM-IV-TR) for non-postnatal depression

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when diagnosing PND, as they are of the opinion that the criteria does not paint the full picture of symptoms experienced by someone with PND. The DSM-5 (APA, 2013) still does not acknowledge postnatal depression as a separate diagnosis, but classifies it as a mood disorder with the specifier “with perinatal onset” (Serati, Redaelli, Buoli, & Altamura, 2016) to include depression that commences during pregnancy (Hoertel et al., 2015; Sharma & Mazmanian, 2014). According to Dalfen (2009), 50% of PND cases develop during the perinatal period and untreated antenatal depression seems to worsen progressively and is likely to continue postpartum (Misri, 2006). Clustering two categories, “with postpartum onset” and “with perinatal onset” under the same specifier, creates a problem in that the differences in epidemiology, presentation and prognosis are ignored and could have implications for treatment efficacy (Sharma & Mazmanian, 2014; Viguera et al., 2000). The DSM-5 (American Psychiatric Association, 2013) further acknowledges the presentation of severe anxiety and panic attacks, but does not allow for a specifier that indicates comorbid diagnosis such as obsessive compulsive disorder (OCD) or anxiety disorders (Sharma & Mazmanian, 2014). According to Everingham, Heading and Connor (2006), in trying to classify PND as a single diagnosis, much of the detail of the true experience of PND is lost. Furthermore, Milgrom et al. (2006b) explain that the term ‘postnatal depression’ should be seen as an ‘umbrella-diagnosis’, that encompasses a range of difficulties and challenges experienced after the birth of an infant. Additionally, Sharma and Mazmania (2014) express disappointment in the fact that the time period of four weeks postpartum (for diagnosis of postnatal depression) was not extended in the DSM-5 (American Psychiatric Association, 2013), as research shows that symptoms can start much later during the postpartum period.

If left untreated, postpartum depression could develop into postpartum psychosis (Luskin, Pundiak, & Habib, 2007). Postpartum (puerperal) psychosis is the most severe form of postpartum mood disturbance (Robertson et al., 2004) and is seen as a psychiatric

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emergency (Puryear, 2007). Postpartum psychosis refers to a rapid de-compensation that occurs within the first four weeks postpartum. It is characterised by severe depression, psychosis, hallucinations, bizarre thoughts/delusions, disorganised thinking, confusion, dramatic mood-swings, agitation, restlessness, and poor insight (Luskin et al., 2007; Morrissey, 2007; O'Hara, 2009; Page & Wilhelm, 2007). This condition carries a high risk of suicide or infanticide and requires immediate inpatient intervention (Alici-Evcimen & Sudak, 2003).

It is important when diagnosing and treating the mother for PND also to consider her partner's mental health (Iles et al., 2011) as fathers are also vulnerable to developing PND and paternal PND is not uncommon (Davé et al., 2010), but is understudied (Boyce, Condon, Barton, & Corkindale, 2007; Edmondson, Psychogiou, Vlachos, Netsi, & Ramchandani, 2010; Matthey, Barnett, Ungerer, & Waters, 2000; Paulson & Bazemore, 2010; Ramchandani et al., 2011). According to research studies, 4% - 25% of new fathers present with PND (Melrose, 2010; Pilyoung & Swain, 2007), while in a more recent study the percentage is reported to be 10% (Giallo, Cooklin, Wade, D'Esposito, & Nicholson, 2012). Paternal PND is related to maternal PND (Pilyoung & Swain, 2007; Salmela-Aro, Aunola, Saisto, Halmesmäki, & Nurmi, 2006), and partners of a depressed individual are at a 40% - 50% risk to also developing depression (Lee & Chung, 2007; Pinheiro et al., 2006). Edhborg et al. (2005) found similarities in mothers and fathers in relation to symptoms of baby blues, impaired bonding and partner's depressive mood and the authors highlight that these experiences are therefore not gender-specific. Towards the latter part of the first year postpartum, when the biological influences have subsided and the couple has had time to adjust to their new roles, partner support and role adaptation seem to have the biggest impact on mood, therefore at this time there is an increase in the risk for couples to both develop PND (Matthey et al., 2000). Mothers and fathers may face similar challenges during this

period (Figueiredo & Conde, 2011; Teixeira et al., 2009), especially in a family where child care and domestic activities are shared more equally. In these couples, men and women have about the same risk of developing PND (Nonacs, 2006).

1.2.2 The aetiology of postnatal depression.

The exact cause of PND is still being studied (Miles, 2011; Wiklund et al., 2010), but after extensive research no single causative factor could be identified (Ayers, Bond, Bertullies, & Wijma, 2016; Dennis & Hodnett, 2007). PND can occur in women after giving birth, suffering a stillbirth, or a miscarriage, or after an abortion (Venis & McCloskey, 2007). Parents who adopt (Venis & McCloskey, 2007) as well as males may develop PND (Davé et al., 2010; Melrose, 2010). PND seems to be the result of a complex interaction of biological, psychological and social factors (Figueiredo & Conde, 2011; Melrose, 2010; Miles, 2011), leading to each person's PND presentation being unique (Craig et al., 2005; Dennis & Hodnett, 2007). Researchers suggest a bio-psycho-social view of the aetiology (Dalfen, 2009; Venis & McCloskey, 2007), and Nonacs (2007) adds cultural factors to this view, explaining that certain cultures have postpartum rituals that could act as a protective factor, whereas cultural expectations or the lack of support in certain Western cultures could contribute to the development of PND.

1.2.2.1 Biological risk factors.

Biological risk factors include physical illness, mental illness, reproductive hormonal changes and obstetric complications.

Medical conditions. Physical illness could precipitate the development of PND. One of the most prominent conditions is abnormal thyroid functioning (Alici-Evcimen & Sudak, 2003; Dalfen, 2009). Approximately 5% of all women develop postpartum thyroiditis, this could involve hyperthyroidism, hypothyroidism or both sequentially. Symptoms include

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fatigue, weight gain, low libido, moodswings, heart palpitations, severe anxiety and an enlarged thyroid gland (Dalfen, 2009; Misri, 2006; Nonacs, 2006).

Psychiatric history. Biological changes imposed on an individual with a genetic and psychological vulnerability seem to trigger depression (Alici-Evcimen & Sudak, 2003; Yim et al., 2015). A personal or family history of a mood or anxiety disorder could increase the risk for developing PND (Alici-Evcimen & Sudak, 2003; Dietz et al., 2007; Lee & Chung, 2007; Rahman, Iqbal, & Harrington, 2003; Sword, Clark, Hegadoren, Brooks, & Kingston, 2012; Wiklund et al., 2010) by 25% as opposed to 10% in the general population (Nonacs, 2006). A personal history of a major depressive episode increases the risk of developing PND by 30 to 40% (Alici-Evcimen & Sudak, 2003). Depression and anxiety symptoms in the antenatal or perinatal period could increase the risk of developing PND by 50% (Dalfen, 2009; Lee & Chung, 2007; Leigh & Milgrom, 2008). Furthermore a history of pronounced baby blues and PND increases the risk of a subsequent PND episode by between 25% and 50% (Alici-Evcimen & Sudak, 2003; Beck, 2001). Individuals presenting with Premenstrual Dysphoric Disorder are also at an increased risk for the development of PND (Alici-Evcimen & Sudak, 2003; Dalfen, 2009; Nonacs, 2006).

Hormonal changes. During pregnancy, women experience intense hormonal fluctuations (Nonacs, 2006), and there seems to be a certain subgroup of females who are particularly sensitive to these normal hormonal changes that accompany pregnancy and child birth (Dennis & Ross, 2006; Yim et al., 2015). Some women seem sensitive to the β -endorphin and present with depressive symptoms 9 weeks postpartum (Yim et al., 2015), while women who are prone to experiencing more intense pre-menstrual symptoms and hormone related mood swings, or experience side-effects from oral-contraceptives also seem to be more vulnerable to developing PND (Dalfen, 2009; Nonacs, 2006).

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During pregnancy, breastfeeding and weaning, the mother's body goes through enormous physical changes and the natural equilibrium of the body is disturbed (Dalfen, 2009; Nonacs, 2006; Paulson, Dauber, & Lieferman, 2006; Venis & McCloskey, 2007). There is a significant increase in the female reproductive hormones oestrogen and progesterone during pregnancy (Puryear, 2007). These hormones interact with neurotransmitters (i.e. serotonin) that regulate emotions (Dalfen, 2009; Nonacs, 2006) and could lead to mood fluctuations and depression (Misri, 2006). Progesterone increases significantly during pregnancy and promotes the breakdown of serotonin, which could have a negative impact on mood. On the other hand, extremely high levels of oestrogen increase norepinephrine and serotonin activity in the brain, contributing to a positive mood (Nonacs, 2006). After childbirth these levels decrease rapidly to the baseline levels (Wisner, Parry, & Piontek, 2002) and a reduction in oestrogen leads to a decrease in serotonin, which could contribute to depression (Misri, 2006). Other hormonal factors that affect mood during pregnancy are the placenta and also elevated testosterone, corticotropin releasing hormone (CRH) and cortisol levels. The placenta stimulates endorphin production, leaving the mother with a general sense of wellbeing; however after the birth these endorphin levels drop dramatically (Venis & McCloskey, 2007). Increased levels of testosterone during pregnancy on the other hand were found to contribute to depressed mood, irritability and anger (Misri, 2006), while emerging research shows a link between PND and high levels of CRH, a hormone that drives the stress response and is present in inflammatory disease (Yim et al., 2015). Additionally women who are highly stressed during pregnancy could produce too much cortisol, which could lead to physiological and psychological problems in mother and infant (Misri, 2006).

At the time of birth and during breastfeeding oxytocin is released. This hormone assists in uterine contractions during labour and the ejection of milk when the infant is

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suckling. It is a natural anti-anxiety hormone, has a calming effect on the mother and enhances the mother's positive feelings towards the infant (Misri, 2006). Furthermore, in the days after childbirth there is a dramatic increase in the prolactin levels to enhance breast milk production. Elevated levels of prolactin hinder the body from producing oestrogen and progesterone, making it difficult for the body to replenish these two hormones that have been depleted during pregnancy. Even when the mother chooses not to breastfeed, or stop breastfeeding, the prolactin levels remain elevated for months. When weaning the baby, the endorphin hormone levels drop as the prolactin levels return to normal. High prolactin levels could exacerbate thyroid problems which contribute to the development of depression (Venis & McCloskey, 2007).

Birth. Obstetric factors like complications during pregnancy or birth, a traumatic birth experience, premature labour, having an episiotomy, postnatal pain, a neonatal medical emergency, as well as pregnancy before a full recovery of a prior birth or pregnancy related trauma could all contribute to the development of PND (Dalfen, 2009; Dietz et al., 2007; Nonacs, 2006; Patel, DeSouza, & Rodrigues, 2003; Robertson et al., 2004; Venis & McCloskey, 2007).

There are however women who experience hormonal changes and birth complications but do not develop PND (Dalfen, 2009). A research study by Mott, Edler Schiller, Gringer Richards, O'Hara and Stuart (2011), indicates that depression levels in birth- and adoptive mothers are comparable, showing an equal vulnerability to the development of depressive symptoms, therefore disproving a pure biological basis for PND. Ongoing research is required in order to establish the extent of effect of the mentioned hormonal changes on the development of PND (Yim et al., 2015), but as PND develops in parents who do not give birth, males included (Melrose, 2010; Nonacs, 2006), other factors should be considered. As previously mentioned, the aetiology of PND is complex, with a combination of risk factors

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leading to its development (Dalfen, 2009). Miles (2011) states that epidemiological studies have consistently reported major aetiological factors to be psychosocial and psychological in nature.

1.2.2.2 Psychological risk factors.

Psychological risk relates to factors regarding upbringing, personality and self-esteem, maternal age and level of education, an unwanted or an unplanned pregnancy, fertility problems, birth experience, adjustment difficulties and unmet expectations, stressful life events, poor coping skills, negative cognitions and factors relating to the infant.

Factors regarding upbringing. When couples have children, negative thoughts regarding their own childhood experiences could be evoked and this could increase their vulnerability to developing PND (Leigh & Milgrom, 2008; Patel et al., 2003). Women who have had conflicted relationships with their parents, did not have their physical or emotional needs met, or were abused in some way are more susceptible to developing PND (Leigh & Milgrom, 2008). The risk also increases if there was a poor mother-daughter bond, or if the maternal mother is deceased (Dalfen, 2009; Milgrom et al., 2006b; Venis & McCloskey, 2007). Adult attachment style is another factor that could increase vulnerability, and parents with insecure adult attachment, (fearful, anxious attachment style) present with higher rates of PND (Leigh & Milgrom, 2008; Wilkinson & Mulcahy, 2010).

Personality and self-esteem. Certain personality traits could increase the risk of developing PND (Nonacs, 2006; Patel et al., 2003), and these include an external locus of control, neuroticism, perfectionism, need for control, excessive worry or low emotional intelligence (Dalfen, 2009; Rode, 2016). Due to the high levels of anxiety that accompany the mentioned personality traits, these qualities could affect an individual's ability to cope (Boyce, 2003). An individual with an inflexible personality style with unreasonably high expectations of the self and others could set herself up for failure as the arrival of a child

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brings about many challenges that are beyond the limits of rigid control, and this could result in feelings of failure (Venis & McCloskey, 2007). Furthermore, a low self-esteem and feelings of incompetence as well as a sense of loss of identity, could increase the risk of developing PND (Beck, 2001; Dennis & Hodnett, 2007; Lee & Chung, 2007; Leigh & Milgrom, 2008; Liu, Chen, Yeh, & Hsieh, 2012; Milgrom et al., 2006b). In women low self-esteem could manifest as doubts in her abilities to be a good-enough mother and wife (Patel, Wittkowski, Fox, & Wieck, 2013). There is a strong association between maternal competence and maternal stress (Liu et al., 2012). Furthermore excessive weight gain after the pregnancy or body image issues and a history of an eating disorder could also contribute to low self-esteem and could help maintain PND (Dalfen, 2009), while in fathers low self-esteem may present as embarrassment or distress due to not being able to support the wife, or feeling left out of the parent-infant dyad (Wang & Chen, 2006).

Age and level of education. Very young or older parents seem to be at a higher risk (Dalfen, 2009; Lee & Chung, 2007). Inexperience or immaturity has been noted to contribute to PND in young mothers (Venis & McCloskey, 2007), while older mothers might have less stamina, energy and patience to deal with childcare activities, are at risk of more health problems (Nonacs, 2006), and may find the adjustment to parenting very overwhelming (Venis & McCloskey, 2007). Furthermore maternal educational level is related to PND (Ramchandani, Richter, Stein, & Norris, 2009; Seymour et al., 2014). According to a study by Page (2008) lower levels of education correlated with higher levels of depression; this could both be a consequence of lower socio-economic status, but also less knowledge about childcare.

Unwanted / unplanned pregnancy or fertility problems. An unwanted or unplanned pregnancy could lead to elevated levels of depression and anxiety (Beck, 2001; Dalfen, 2009; Lee & Chung, 2007; Robertson et al., 2004). On the other hand, a much desired pregnancy

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after fertility treatment could increase the risk for PND as these treatments take a toll on physical, emotional, financial and relationship stability (Dalfen, 2009; Nonacs, 2006; Venis & McCloskey, 2007).

Birth experience. The birth experience can be both a biological as well as a psychological vulnerability factor. Disappointments regarding the birth (e.g. hoping for a natural birth and having to undergo a C-section, birth trauma or experiencing a difficult delivery, the partner's absence during the birth) and previous pregnancy-related problems (e.g.: abortion, miscarriage, interrupted pregnancy, stillbirth, fertility problems, and unexpected multiple births), could all contribute to the development of PND (Dietz et al., 2007; Liu et al., 2012; Milgrom et al., 2006b; Nonacs, 2006; Patel et al., 2003; Robertson et al., 2004).

Adjustment difficulties and expectations. The transition to parenthood is noted for being a period of increased stress (Nonacs, 2006). Adjustment difficulties or unrealistic expectations of pregnancy or parenthood (Dennis & Hodnett, 2007; Patel et al., 2003; Sword et al., 2012), coupled with sleep deprivation and chronic pressure managing the demands of different roles, financial problems or work-related stress, are strong predictors of PND (Yim et al., 2015). There is a reciprocal relationship between parenting stress and depression (Leigh & Milgrom, 2008; Yim et al., 2015) and parents can easily feel overwhelmed by all the adjustments during the parenting transition, and in turn this could lead to feelings of anxiety, frustration and depression (Venis & McCloskey, 2007).

Furthermore, breastfeeding can be very demanding physically (Dalfen, 2009). A mother who struggles to breastfeed and is sensitive to the perceived expectations of others, (e.g. the husband, parents, friends and the community), might feel like a failure if she cannot manage, and this could elevate the risk of developing PND (Dalfen, 2009; Venis &

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McCloskey, 2007). Finally disappointment with regards to the child's gender could precipitate PND (Dalfen, 2009; Rahman et al., 2003; Venis & McCloskey, 2007).

Stressful life events. Stressful life events that take place during or near the delivery date (e.g. the death of a loved one, relationship difficulties, low marital satisfaction or divorce, conflict between the new mother and her parents, job-loss, unemployment or financial strain in either partner, moving home and socio-economic status, could interact with the individual's chances of developing depression (Alici-Evcimen & Sudak, 2003; Leigh & Milgrom, 2008; Milgrom et al., 2006b; Patel et al. 2013; Robertson et al., 2004; Sword et al., 2012; Wiklund et al., 2010).

Poor coping skills. Poor social skills (Milgrom et al., 2006b) and coping skills like the use of alcohol or drug abuse and smoking (Dietz et al., 2007; Lee & Chung, 2007) also seem to increase the risk of developing PND. According to Misri (2006), women are raised to believe that it is inappropriate to express emotions. Females tend to believe that they are alone in their struggle to cope, and would avoid reaching out for help in an attempt not to appear weak or like a failure.

Cognitions. Negative thinking patterns and cognitive distortions as well as a negative attitude towards child rearing, could cause parents to doubt their parenting abilities and not enjoy the parenting experience. Unrealistic expectations of self or views prescribed by others could increase the risk of developing PND. Another cognitive factor that contributes to PND is feelings of guilt regarding the discrepancy between what the parent feels she/he is supposed to be doing and is able to accomplish in reality (Leigh & Milgrom, 2008; Patel et al., 2013; Seymour et al., 2014; Sword et al., 2012).

Factors related to the infant. Parenting stress related to a child's temperament or having a child with an illness or disability who needs a great deal of care could be very

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overwhelming and challenge any parent's coping resources (Dalfen, 2009; Milgrom et al., 2006b; Nonacs, 2006; Sword et al., 2012; Venis & McCloskey, 2007).

1.2.2.3 Social risk factors.

Social factors include the interpersonal relationship with the intimate partner and quality of support, which also take account of cultural attitudes towards PND.

Interpersonal relationship with intimate partner. Many couples experience relationship dissatisfaction and an increase in conflict after starting a family (Condon, Boyce, & Corkindale, 2004; Schulz et al., 2006; Wilkinson & Mulcahy, 2010). This is most probably because of violated expectations of parenthood, partnership in parenting and the adjustment to becoming a parent (Krieg, 2007).

One of the biggest risk and maintaining factors for PND is a poor marital or partner relationship (Lee & Chung, 2007; Ramchandani et al., 2009; Seymour, et al., 2014; Sword et al., 2012; Wilkinson & Mulcahy, 2010; Yim et al., 2015). The percentage of postnatal couples, in which at least one of the parents is depressed, is high. Condon et al. (2004) state that 15% of new fathers have a partner with PND, and the prevalence where both parents are depressed is noteworthy (Goodman, 2004). There is a high comorbidity rate (24-50%) between maternal and paternal PND (Pilyoung & Swain, 2007). According to Venis and McCloskey (2007), a third of women who are diagnosed with PND have a depressed partner.

Limited / poor support. There is a strong association between poor support and depression (Divney et al., 2012), while good quality relationships and social support could be protective factors (Pilkington et al., 2016; Venis & McCloskey, 2007; Yim et al., 2015). Perceived lack of support increases levels of anxiety (Seymour et al., 2014), is influential in the development of depression and impacts significantly on the depressed person's ability to cope with stress in the postnatal period (Kathree & Petersen, 2012). According to research,

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women tend to turn to their intimate partners for support. When emotional and practical support is not provided by the partner, the mother may well feel overwhelmed and isolated, could struggle to cope and subsequently could develop depression (Boyce, 2003; Seymour et al., 2014).

Both partners may be affected by a perceived lack of support or inadequate levels of informational, instrumental and emotional support (Lee & Chung, 2007; Leigh & Milgrom, 2008; Robertson et al., 2004; Sword et al., 2012; Wiklund et al., 2010; Wilkinson & Mulcahy, 2010), while being a single mother could be extremely stressful and, if adequate support is unavailable, the risk of developing PND is significantly higher (Beck, 2001; Dietz et al., 2007; Nonacs, 2006; Venis & McCloskey, 2007).

Parenthood is complicated by the fact that pregnancy is culturally celebrated and that society holds the expectation that the parents would be joyful during this time (O'Hara, 2009). Cultural variables can play a unique role in the occurrence, care and treatment of PND (Miles, 2011) and could both be a positive or negative influence in the postnatal period (Bina, 2008). PND was considered to be a Western phenomenon in the late 1970s and throughout the 1980s. Some cultures do not have direct equivalents for terms like depression or anxiety. This is an important consideration when screening for depression (Patel, Abas, Broadhead, Todd, & Reeler, 2001). The description of the experience of 'morbid unhappiness' (Oates et al., 2004) or 'internalising misery' (Wittkowski, Zumla, Glendenning, & Fox, 2011) does, however, fit the Western diagnostic criteria for PND, but it is not recognised in other cultures as a diagnosable illness that requires professional intervention (Babatunde, 2010; Oates et al., 2004). Research has revealed that PND is a negative outcome post-birth for women of different cultures, and, across cultures, the cause for this condition seemed to include marital or family relationship problems and lack of/ limited emotional and practical support (Cox & Holden, 2007; Alici-Evicmen & Sudak, 2003). In cultures where a lot of care and attention is

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given to the new mother after birth, there are few reports of PND (Rahman et al., 2003).

Involvement and practices performed by extended family in non-Western societies appear to be an important protective factor, but these practices seem to be on the decline (Kathree & Petersen, 2012; Misri, 2006; Rahman et al., 2003). It seems as if there is a risk that many African women will not be diagnosed and treated, as they have learned to hide their difficulties post-birth for fear that they might appear weak and that they will be stigmatised (Babatunde, 2010). Parents who are not coping could withdraw and isolate themselves. This reduces the levels of available resources of support and could maintain and exacerbate the symptoms of depression (Alici-Evcimen & Sudak, 2003; Dennis & Hodnett, 2007; Patel et al., 2013). Furthermore, some cultures still have strong traditional gender roles, with men being uninvolved or minimally involved in childrearing and household chores (Kathree & Petersen, 2012). Women who participated in a study by Babatunde (2010), complained that their partners were uninvolved and claimed that this problem is an 'African-thing'. The lack of partner support could have a negative impact on the mother's ability to cope, while simultaneously society still seems to have higher expectations of the mother as carer and nurturer than of the father (Carneiro, Corboz-Warnery, & Fivaz-Depeursinge, 2006).

Research needs to continue to determine the reasons why certain parents develop PND while others do not (Sword et al., 2012).

1.2.3 The impact of postnatal depression.

According to systems theory, what affects one family member will have a direct or indirect impact on the rest of the family (Bitter & Corey, 2005). A parent's depression could thus have serious implications for the whole family's health and wellbeing (Goodman, 2004).

1.2.3.1 The impact of postnatal depression on the mother.

About a third of women who present with PND will continue to have symptoms for one year post delivery, and will be more vulnerable to subsequent episodes of depression (Nonacs, 2006). Depression often leads to feelings of vulnerability, loneliness and helplessness and could prevent the individual from seeking help or support (Morrissey, 2007). If left untreated, PND could contribute to lasting symptoms of anxiety and tension, negative mood, depression, anger and hostility, fatigue, confusion, bewilderment and apathy (Milgrom et al., 2006a) and these symptoms could continue well beyond the first year postpartum (Siu et al., 2011).

Postnatal, the demands of parenthood are extensive, and could include twenty-four-hour parenting, maintaining the home and continuing with household chores, returning to work and juggling all of the old and new responsibilities. These demands in themselves are taxing, but if a person has depression this could seem completely unachievable (O'Hara, 2009). Due to the mother's central role in the family, maternal PND may have far reaching consequences for the care and development of her baby, the marital relationship and the family as a whole (Dennis et al., 2012; Likierman, 2003; Mulcahy et al., 2010).

1.2.3.2 The impact of postnatal depression on the mothering role.

Postnatal depression develops during a critical time in the mother-child relationship (Emanuel, 2006), disrupts the mutual bonding process between mother and infant and could have a detrimental impact on the development of secure attachment (Nonacs, 2006).

According to Psychodynamic theory the mother is responsible for creating a "holding" environment wherein she is able to contain the infant's stresses and discomfort and the infant feels safe to explore the world. If the mother is battling with PND, she might not be able to create this safe space for her baby (Likierman, 2003).

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Furthermore, PND occurs at a time when heavy demands are being made on the parents' resources and when infant development and learning is at a critical stage (Cox & Holden, 2007). The first years of infancy create the platform for future mental and socio-emotional development (Venis & McCloskey, 2007). The mother's attention to the child's actions, cues and her responsiveness to these are vital for normal development (Logsdon, Wisner, & Pinto-Foltz, 2006; Puckering et al., 2010; Stein, Lehtonen, Harvey, Nicol-Harper, & Craske, 2009). A thoughtful, attentive parent helps the infant make sense of the world by way of empathic attunement, appropriate and predictable responsiveness, mirroring and pacing behaviour according to infant cues, physical stimulation, emotional interplay, and this helps the infant to modulate distress (Milgrom et al., 2006b).

Depression is, however, associated with "self-focus" (Mor & Winqvist, 2002) and problems related to disengaging from negative thoughts (Stein et al., 2009). Even though the mother is physically present, she may be emotionally detached and unresponsive (Buultjens, Robinson, & Liamputtong, 2008; Lee & Chung, 2007; Lusskin et al., 2007; Nonacs, 2006). Mothers who suffer from PND have significant problems regarding sensitive responding to their infants (Campbell et al., 2004), they are less warm (Barker, Jaffee, Uher, & Maughan, 2011) and attuned, unresponsive, less stimulating and dependable (Milgrom et al., 2006b). Mothers show disinterest and feelings of ambivalence towards the baby (Melrose, 2010), and they could be more irritable, hostile (Paulson et al., 2006) and less able to engage in positive interactions during play or feeding (McLearn, Minkovitz, Strobino, Marks, & Hou, 2006). Others could be preoccupied with negative thoughts, ruminate about their parenting skills, become overly protective and intrusive and interfere with activities, rather than support exploration (Lee & Chung, 2007; Lusskin et al., 2007; Nonacs, 2006; Stein et al., 2009).

Extensive research has been done with regards to maternal PND, due to the reported association with behavioural, cognitive, psychological and social problems that present in the

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children of mothers who suffer from PND (Davé, et al., 2010; Dørheim, Bondevik, Eberhard-Gran, & Bjorvatn, 2009; Ramchandani et al., 2008, Ramchandani et al., 2011) and there is substantial research evidence that maternal PND is associated with compromised infant care (Barker et al., 2011; Toth, Rogosch, Manly, & Cicchetti, 2006). Many mothers additionally present with feelings of shame and guilt regarding their feelings and behaviour towards the infant (Beck & Indman, 2005). This enhances their doubt in their ability of being a good-enough mother.

If there is a supportive, available partner and parent in the family where one parent is depressed, other family members seem to fare better regardless of the depression (Nonacs, 2006), yet the impact of the depression may have a negative effect on the healthy partner, creating psychological distress and making it difficult to take on a supporting role (Roberts, Bushnell, Collings, & Purdie, 2006).

1.2.3.3 The impact of maternal postnatal depression on the father.

The significant other is most likely to experience the impact of the negative effects of the depression, while having to work extra hard to maintain the couple's relationship, the family and ensure the household runs smoothly (Nonacs, 2006). According to Roberts et al. (2006), one in ten men deal with the dual stressor of living with a depressed partner and having to take over the primary care of an infant.

There is an increased risk for a person whose partner suffers from a mental illness i.e. depression, in the postnatal period, also to develop psychological distress (Roberts et al., 2006; Wee, Skouteris, Pier, Richardson, & Milgrom, 2011), like severe fatigue and more complex psychological distress for example: depression, anxiety and substance abuse (Roberts et al., 2006). Partners can become caught up in the emotions of the depressed

individual; and they could feel vulnerable and helpless in dealing with their partner's emotional difficulties (Morrissey, 2007).

1.2.3.4 The impact of maternal postnatal depression on the couple.

Parents who are depressed may lose interest in daily activities or friendships. They may become withdrawn and isolate themselves and could experience problems with regards to emotional and physical intimacy (Iles et al., 2011). This could contribute to distance in the couple relationship and lead to feelings of isolation, both partners could feel unsupported, and could experience escalated levels of conflict and lower desire for intimacy (Nonacs, 2006). Poor social support could contribute to the development and maintenance of PND (Wang & Chen, 2006), however, insecurity and depression could also alter the person's perception of interpersonal relationships (Wilkinson & Mulcahy, 2010), leading to difficulties regarding accepting and noticing support from others.

How a partner responds to the person who suffers from depression is crucial to the health and wellbeing of the individual as well as the couple's relationship (Nonacs, 2006). If the intimate partner does not understand the condition, it may lead to feelings of anger and frustration and there is a risk that he/she will invest more time in activities where he/she feels comfortable and in control, i.e. work, sport etc. (Everingham et al., 2006). This in turn could increase the inequities in parenting responsibilities, add to relationship discord and aggravate the depressive symptoms (Shapiro & Gottman, 2005).

A strong relationship, where partners experience emotional closeness and support could be a protective factor against the development of PND (Dennis & Ross, 2006; Pilkington et al., 2016), and a healthy, involved partner could minimise the effect of the PND on the rest of the family (Dudley, Roy, Kelk, & Bernard, 2001; Edhborg et al., 2005; Pilyoung & Swain, 2007).

1.2.3.5 The impact of maternal postnatal depression on children in the family system.

1.2.3.5.1 Impact on the infant. The impact of PND on children could be direct or indirect (Correia & Linhares, 2007). An indirect impact could be a hostile home environment due to marital discord, while a direct effect could include the parenting style, child neglect or under-stimulation (Shapiro & Gottman, 2005). The long-term effects of untreated parental depression could result in insecure attachment which in turn would lead to impairments in social, adaptive and emotional functioning (Barker et al., 2011; Davé et al., 2010; Huang et al., 2012; Pilyoung & Swain, 2007; Puckering et al., 2010; Puryear, 2007). Insecure attachment may last beyond the duration of the PND (Jung, Short, Letourneau, & Andrews, 2007) and lead to severe psychological, cognitive and emotional consequences. (Barker et al., 2011; Lusskin et al., 2007; Lyons-Ruth, Wolfe, & Lyubchik, 2000; Melrose, 2010; Milgrom et al., 2006b; Pilyoung & Swain, 2007; Vrieze, 2011).

1.2.3.5.2 Other children in the family system. PND not only affects the newborn infant, but could also has a serious impact on the infant's siblings (Vrieze, 2011). Parents who are suffering from depression tend to be more critical and tend to openly criticise their children; these negative messages could become internalised and result in low self-esteem, a sense of hopelessness and put the child at risk of developing depression (Nonacs, 2006). Additionally, severe cases of parental depression put the infant and siblings at risk of maltreatment and infanticide (Alici-Evcimen & Sudak, 2003; Pilyoung & Swain, 2007).

Because of the profound impact of postnatal depression on both the individual suffering from PND and the system of which this individual is a part, continuous research on all aspects of postnatal depression is encouraged (O'Hara, 2009).

1.2.4 Interventions used in the treatment of postnatal depression.

As mentioned the aetiology of PND is complex and there are many variables interacting in the development thereof (Ayers et al., 2016); therefore, a variety of treatment options exist, focussing on different risk and protective factors.

1.2.4.1 Interventions focussed on the mother.

Individual therapy, seems to be effective in treating maternal mood. A number of psychosocial interventions, including counselling, Cognitive Behavioural Therapy (CBT), Interpersonal psychotherapy (IPT) and Psychodynamic therapy, have proved successful in the treatment of PND (Dennis & Hodnett, 2007; Milgrom, Negri, Gemmill, McNeil, & Martin, 2005; Ramchandani et al., 2009).

Rogierian, client-centred therapy is a treatment modality that proves successful in treating PND if the patient has a good relationship with the healthcare provider prior to developing PND (Henshaw, Foreman, & Cox, 2004).

Cognitive Behaviour Therapy is widely used in the treatment of PND and was recorded by mothers to be helpful (Ugarriza, 2004). Misri (2006) reports on a study by Chabrol and colleagues at the Universite de Toulouse-Le Mirail in France, where CBT was used as a treatment for PND in the absence of medication: patients showed positive recovery rates. According to Craig et al. (2005), CBT is very useful as it targets negative cognitions and lack of interest in activities, features which are prominent in PND. Milgrom et al. (2005),

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on the other hand, found no significant difference between the efficacy of CBT and counselling in the treatment of PND.

Interpersonal parenting education also proved successful in the treatment of PND (Misri & Kendrick, 2007). Interpersonal psychotherapy focusses on disruptions in relationships, role transitions and parent-infant interactions (Alici-Evcimen & Sudak, 2003). The focus falls on themes like: loss, grief and bereavement, strengthening or ending relationships, effective coping skills in life transitions, addressing poor self-esteem and effective interpersonal skills. A study on the use of interpersonal therapy in the treatment of PND, done by Dr. Spinelli at Columbia University, show significant improvement in mood and indicates potential for the prevention of PND (Misri, 2006).

Psychodynamic therapy has been found to be effective in treating PND, especially in those caregivers whose family history impacts on their ability to parent effectively. The focus of psychodynamic therapy is to link current behaviour to the individual's past experience, with specific reference to childhood (Misri, 2006).

A challenge with regards to therapeutic interventions is that women minimise their symptoms due to the stigma related to mental illness and the lack of knowledge about the condition and the seriousness of the symptoms (Ugarriza, 2004).

1.2.4.2 Interventions focussed on the mother and infant.

Mother-infant psychotherapy explores parent-infant interactions, provides corrective supervision or guidance and increases maternal sensitivity and responsiveness (Nylen, Moran, Franklin, & O'Hara, 2006). According to Milgrom et al. (2006b), mother-infant/parent-infant psychotherapy is rare in the context of PND. There are various benefits to parent-infant psychotherapy, as on the one hand, it addresses the parent's difficulties, and on the other, it helps the parent to create a nurturing environment for the baby, in an attempt to

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prevent or repair the negative impact of parental depression on the infant's growth potential (Nylen et al., 2006). According to De Camps et al. (2016), various mother-infant interventions have shown positive results in improving the mother's mood, but they state that this kind of intervention is resource intensive, and group mother-infant therapy is therefore suggested as an alternative.

1.2.4.3 Group Interventions.

Due to the costs involved in individual therapy and the lack of the availability of qualified professionals, group therapy may offer an effective alternative (Scope, Booth, & Sutcliffe, 2012). Group therapy has also shown positive results in the treatment of PND. Mothers in the Mellow Babies study indicated that they preferred a group intervention approach (Puckering et al., 2010) as participants feel supported and realize that they are not alone or that their circumstances are not unique (Craig et al., 2005; Misri, 2006; Ugarriza, 2004). A group-intervention based on CBT proved effective in the treatment on PND (Craig et al., 2005) and according to a study by Honey, Bennett and Morgan (2002), group psycho-education had positive effects lasting longer than six months post termination of intervention, while Pfeiffer, Heisler, Piette, Rogers and Valenstein (2011) found that peer support groups were more effective in alleviating depression than usual primary care, and that the efficacy in the treatment of PND compared well with CBT groups. Parent-infant psychotherapy groups aim to enhance parental sensitivity to parent-infant communication and encourage the development of normal attachment behaviour in infants (Bain, Rosenbaum, Frost, & Esterhuizen, 2012).

1.2.4.4 Couples' Interventions.

Interpersonal couples' therapy. Clatworthy (2000) did a comprehensive research study on effective interventions for PND and found that the majority of effective

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interventions for PND addressed interpersonal relationships and conflict, but were only delivered to women. Most prenatal classes now invite fathers to participate, but the sessions primarily focus on labour and delivery, not on adjustment to pregnancy, the transition to parenthood and the change in family dynamics (Pilkington et al., 2016; Schulz et al., 2006). Depression in one parent indicates the need for clinical attention and support for the other partner (Paulson & Bazemore, 2010). According to Matthey et al. (2003), in order to render an efficient service to postnatal families, the father / partner needs to be assessed for anxiety or mood features on an ongoing basis and communication patterns need to be addressed, while parents should also be helped to express their needs and find effective ways to obtain support. Therapy needs to look at role expectations, and psycho-education has to be done in order to establish better understanding and empathy for each partner. A study by Gordon and Gordon, showed lasting positive results 6 months after couples attended 2 therapy sessions (Misri, 2006).

Group therapy for couples. According to Wang and Chen (2006), well-designed professional groups are very important in the prevention of PND in couples. Effective parenting programmes include conflict management, education and coping skills regarding dealing with labile mood and PND, facilitation of the defining new roles and the continued involvement of the new father in the parenting process, strengthening of the marital friendship and intimacy as well as childcare education and skills regarding play with children (Shapiro & Gottman, 2005).

1.2.4.5 Parenting programmes for mothers.

There are various parenting programmes with different focus areas that were not specifically developed as PND programmes, but could be effective in alleviating depressive symptoms because these focus on addressing risk factors that could contribute to the

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development of PND, like feelings of incompetence, parenting stress, poor support, relationship problems and negative cognitions. These include groups like the *First Baby Project* that teach parenting skills and address self-efficacy and feelings of incompetency. *The Mellow Babies programme* focusses on mother-infant attunement, interactive coaching, baby massage, infant focussed speech and cognitive behavioural strategies as well as support for the mother. The *HUGS (happiness, understanding, giving and sharing) model* (Milgrom et al., 2006b) mainly focusses on parenting skills but also contains a CBT component where negative cognitions, attitudes and beliefs are challenged and further emphasises the establishment of joyful parent-infant interactions and the *Getting ahead of Postnatal Depression group* by Milgrom et al (2006b) which deals with CBT and behaviour modification.

1.2.4.6 Parenting programmes for both parents.

The Becoming a family project, consists of group-therapy paying attention to the joys and stressors in the transition to parenthood, and has achieved positive results regarding paternal involvement in parenting, marital satisfaction and sex postpartum (Schulz et al., 2006; Shapiro & Gottman, 2005). *The EPIC programme* involves psycho-education with regards to milestones, social and learning activities and the promotion of play; guided interactive stimulus for mother and infant; and activities to boost morale and mood, and distract from problems and anxieties (Buultjens et al., 2008). These programmes are not PND programmes, but once again address risk factors that could contribute to the development and maintenance of depression.

Bringing Baby Home. The only parenting programme that could be found that focusses on a holistic intervention and includes both parents throughout the process, is the *Bringing Baby Home* programme. It is a 16 hour, weekend psycho-communicative-

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educational workshop aimed at ensuring a smooth, positive transition into parenthood.

Attendees of the workshop are expectant parents or parents who have recently had a baby.

The programme has three treatment goals: strengthening the marital bond and preparation for parenting challenges as a couple; facilitating both parents' involvement in childrearing; and psycho-education with regards to child development and parenting. Positive outcomes were shown with regards to marital quality, postpartum depression and observed marital hostility. Even though the study showed positive outcomes regarding PND, it was not designed as a postnatal depression workshop, but rather as a parenting programme in general. (Shapiro & Gottman, 2005).

Dennis and Hodnett (2007) state that because of the multifaceted interconnected factors that contribute to the development of PND, interventions focussed on singular risk factors, or only the mother, will not be effective in the treatment of PND. Integrated holistic interventions, that could be adjusted according to the specific needs of individuals and families are recommended (Hunt, 2006; Kane & Garber, 2004; Kathree & Petersen, 2012; Solomonov & Barber, 2016).

1.3 Research Method

1.3.1 Research aims.

The aims of this study are set out below.

- The first aim was to explore how couples experience postnatal depression, as it presents in mothers, in a group of parents in a South African setting.
- The second aim was to identify themes by means of an analysis of the literature and from the outcome of the semi-structured interviews, in order to determine what needs

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to be included in an integrative parenting programme for parents where the mother suffers from postnatal depression, with the purpose of compiling such a programme.

- The third aim was to present the integrative parenting programme to a panel of experts in order to evaluate the quality of the structure and content of the programme, this was done with the aim of refining the programme. The Delphi method was utilised for this purpose.

1.3.2 Research paradigm and design.

A qualitative research paradigm was employed for the purpose of this research and the research process was inductive (Merriam, 2009). Qualitative research involves the systematic gathering, organisation and analysis of textual material, obtained by careful observation or interviewing of, or discussions with participants (Malterud, 2001). It aims both to facilitate a better understanding of the phenomenon that is experienced and also to make meaning through constructivism (Bryman, 2006; Merriam, 2009). The data obtained from both aims one and three was richly descriptive (Merriam, 2009). The researchers inductively developed meaning from the gathered data as it emerged (Bloomberg & Volpe, 2012).

With regards to the first research aim, the researcher was interested in how the participants experience certain life events and the meaning they attach to these experiences (Merriam, 2009), the data obtained from the first aim, was analysed and organized into meaningful categories. These themes, combined with themes from the literature, informed the content and structure of a parenting programme for couples who experience maternal PND (research aim 2).

With regards to research aim 3, a qualitative approach enabled the researcher to understand maternal PND and the unique needs for couples who experience it, by exploring the perspectives of professionals actively working in the field. This helped to modify the

programme, according to the requirements for the wellbeing of this population, as highlighted in professional practice.

1.3.2.1 The research design for objective one.

The design of the first aim of this research project (*how couples experience postnatal depression, as it presents in mothers, in a group of parents in a South African setting*) is exploratory and descriptive in nature. Explorative research is done for the following purposes: to assist in a greater understanding of a certain phenomenon; to test the viability of conducting a bigger study, and to develop methods to be used in a follow-up study (Babbie, 2015). Explorative studies explore the nature of a phenomenon as it occurs under normal circumstances (Gray, 2014), in order to gain new knowledge or insight about the phenomena (Denscombe, 2014). The first step in explorative research is thus to attempt to gain an intimate understanding or awareness of the phenomenon being researched (Givens, 2008).

Similarly, descriptive research attempts to create a picture of the phenomenon and show how certain aspects in the presentation of the phenomenon could interact with each other (Gray, 2014). According to Rossman and Rallis (2012), case studies can be used in exploratory and descriptive research whereby an understanding of the phenomenon is obtained by examining specific cases in-depth. Descriptive studies highlight the complexities of the phenomenon as well as the participant's understanding of it (Rossman & Rallis, 2012).

1.3.2.2 The research design for objective two.

The research design of the second aim (*to identify themes by means of a literature analysis and from the data obtained from the semi-structured interviews, with the aim of determining what needs to be included in an integrative parenting programme for parents where the mother suffers from postnatal depression*), of this study is an interpretive research design. Interpretive research is inductive in nature and is often associated with data gathering and analysis in qualitative research (Gray, 2014).

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According to the interpretive approach, reality, meaning or experience is socially constructed and people attribute subjective meaning to personal experiences (Bloomberg & Volpe, 2012; Braun & Clarke, 2006). Therefore, no single ultimate reality exists (Merriam, 2009). The aim of qualitative interpretive research is to describe, elucidate and understand a specific phenomenon / experience as experienced subjectively by each participant (Bloomberg & Volpe, 2012; Creswell, 2014; Merriam, 2009). The researcher is interested in how the participants interpret, understand and experience their social world (Skulmoski, Hartman, & Krahn, 2007); and comes to understand and make meaning or gather knowledge of the participants' experience by engaging with them (Braun, Clarke, & Terry, 2015).

1.3.2.3 Research design for aim three.

The research design for aim three (*to present the integrative parenting programme to a panel of experts for the evaluation of the proposed programme, with the aim of refining the programme*) was exploratory (Keeney, Hasson, & McKenna, 2011; Yousuf, 2007). As per the Delphi method, questionnaires can assist researchers in exploring experts' opinion regarding the phenomenon that is researched (Keeney, Hasson, & McKenna, 2011). Experts in this study commented on the feasibility, usefulness and quality of a proposed programme for couples who experience maternal PND.

1.3.3 Procedure.

The research was divided into the following phases:

Phase one involved a thorough literature study focussed on the nature of PND, the diagnostic criteria, aetiological factors as well as the impact of maternal PND on the mothers' as well as the families' wellbeing.

Phase two, involved obtaining permission to conduct the research from the Health Research Ethics Committee of the Faculty of Health Sciences (HREC) at the North-West

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University, Potchefstroom Campus (NWU-00125-11-S1). Upon approval, institutions (clinics and schools) were approached to assist in finding suitable research participants, and written consent was obtained from these institutions. Mediators were identified and requested to raise awareness for the project; mothers who indicated that they were willing to participate were requested to leave their contact details with the mediator. They were furthermore requested to complete two self-report questionnaires namely the Edinburgh Postnatal Depression Scale (EPDS) and the General Health Questionnaire-28 (GHQ-28) to determine the presence of postnatal depression symptoms. The EPDS and the GHQ-28 are screening instruments and were used purely to identify suitable participants, and the data from these screening instruments were not used for any other purpose in this study. The project head contacted the mothers who met the inclusion criteria and requested mothers and their partners to participate in an interview with their project head.

In phase three, 13 couples agreed to be interviewed by the project head. Appointments were scheduled at a venue that was convenient for the couples and at a time when both partners were available.

During phase four the project leader met with couples, explained the nature and requirements of participation in the study in detail and requested couples to sign an informed consent form that included all the explained details. Participants were granted the opportunity to ask questions and obtain clarity on what was required of them. Once the couples were satisfied with the information provided and felt comfortable about proceeding, they were interviewed by means of a semi-structured interview that was designed to target specific areas of concern as stipulated by data gathered from the literature review.

In phase five, data gathered from the interviews were analysed by means of thematic data analysis. A co-analyst corroborated and added to the findings.

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During phase six, the preliminary parenting programme was compiled using the data gathered in the literature analysis as well as the semi-structured interviews.

In phase seven, 63 professionals from different mental health disciplines were invited by a mediator to participate in the evaluation of the proposed programme, as Delphi experts. The nature of the study and also the expectations of experts were explained to experts and they were requested to sign a written consent form, detailing all relevant information regarding the purpose of the study as well as the responsibility and rights of participants. Out of the 63, ten professionals agreed to participate in the study.

Phase eight entailed the evaluation of the quality and content of the proposed programme, employing the Delphi method.

During phase nine, the integrative parenting programme was refined and adapted on the basis of feedback obtained from the Delphi evaluations.

Finally, in phase ten, the programme was submitted for consideration for publication in an academic journal.

It is envisioned that this programme will be published in future and used in offering training for healthcare professionals and conducting workshops for couples who experience maternal postnatal depression.

1.3.4 Participants and context.

1.3.4.1 Postnatal couples.

Participants were recruited by means of purposive volunteer sampling, with the aim of gaining a good understanding (Bloomberg & Volpe, 2012; Merriam, 2009) of the maternal postnatal depression as experienced by couples. Thirteen multiparous couples, where the mother scored higher than 9 (Cox & Holden, 2007) on the Edinburgh Postnatal Depression Screening Scale (EPDS) within 12 months postpartum, were considered for this study.

Furthermore in line with recommendations in the literature, the General Health

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Questionnaire-28 (GHQ-28) was administered to increase the positive predictive value and to confirm the PND symptoms as indicated by the EPDS (Wylie et al., 2011). The use of these screening scales required participants to be proficient in English. To preclude the possibility of pre-existing depression, parents with a recent history of depression unrelated to the postnatal period were excluded from this study. The average age of moms at the time of the interviews was 33 and for the dads 36. The average age of moms at the time of their first pregnancy was 24 with the youngest being 15 and the oldest 37. Among the 13 couples, nine had two children, three couples had three children and one couple had four children. Two of these families were merged families, with children from different partners. Couples were either married or co-habiting and presented with varying socio-economic circumstances.

1.3.4.2 Delphi panel participants.

Purposive volunteer sampling was also used for the sample of professionals. A mediator sent emails regarding the research project to 63 healthcare professionals who are listed on a health professional data-base, and indicated a special interest in working with PND. The emails contained an overview of the project. Those healthcare professionals who expressed an interest in participating in the study received detailed information about the project, including what would be expected of participants, requirements regarding professional expertise, the right to confidentiality as well as to withdraw from the study. Professionals working actively in the field of PND was specifically identified in order to gain a good understanding (Bloomberg & Volpe, 2012; Merriam, 2009) regarding the essential elements to consider when developing a programme for couples who present with maternal PND, from the perspective of professionals with the relevant experience. The inclusion criteria used for this sample of professionals entailed: a strong interest in PND; knowledge and experience in the field; professional registration with a regulatory board; no less than two years of professional experience consulting with mothers who experience PND; and adequate

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time to participate in the Delphi process. The final panel was made up of ten professionals, including three psychiatrists, three clinical psychologists, one educational psychologist, two clinical social workers and one professional nurse. One participant is jointly registered as a research psychologist and two professionals also lecture. The panel's professional experience range between two years (specialist practitioner) and thirty-five years.

1.3.5 Data collection.

1.3.5.1 Data collection for the purpose of compiling a parenting programme.

A thorough analysis of the literature provided the theoretical basis for the programme and informed the content of a semi-structured interview in order to gather data pertaining to the lived experience of couples where the mother suffers from PND. The interview consisted of both structured questions, focussed on the research topic and requiring specific information from all participants; and less structured questions to allow for exploration of each participant's experience (Merriam, 2009). The interview was done with both partners concurrently. Questions included in the interview focussed on demographic information; birth, postnatal and developmental history of all infants included in the family; the parents' own childhood experience relating to the family of origin; the parents' experiences relating to the most recent pregnancy and care of the infant; the parents' feelings regarding being a parent; the challenges pertaining to childcare and parenting; the parents' concept of self; the impact of parenting on other roles and responsibilities; the parents' emotional wellbeing and attention to self-care; the couples' relationship and impact of parenting thereof and the parents' coping abilities and resources of support. The questions were semi-structured, allowing parents to elaborate and add information that were relevant to their experience.

1.3.5.2 Data for the refinement and finalisation of the proposed programme.

A qualitative Delphi method consisting of two rounds of evaluation, was used to gather data from experts in the field of PND, with the purpose of improving the quality and content of the proposed programme. In order to encourage honest feedback, the process remained confidential (Ter Haar, Aarts, & Verhoeven, 2016). In that names were not linked to any contributions during the two Delphi rounds. The project head was, however, able to link the data to specific professionals, to enable follow-up during the Delphi process.

During round one experts received an electronic copy of both the facilitator manual for the proposed programme as well as a questionnaire consisting of two parts. The first part gathered data regarding the professional's experience in the field, whereas the second part was focussed on the critical evaluation of the structure, content and process of the proposed programme. The evaluation was returned to the project head via email within a two-week period. Data from the first round was analysed by means of thematic data analysis, and a summary of the themes and findings was sent to panel members during the second round. Experts were requested to consider and comment on the feedback of other professionals as well as to clarify or make changes to their initial feedback. Feedback was once again returned electronically within a two-week period.

1.3.6 Data analysis.

Data gathered from both the semi-structured interviews with couples as well as the Delphi method was analysed by means of thematic data analysis. Themes within the data were defined, explored and reported (Braun, Clarke, & Terry, 2015; Clarke & Braun, 2013) with the aim of gaining a thorough understanding of: (1) couples' experience of maternal postnatal depression; and (2) the essential elements that need to be considered when compiling a programme for couples who experience maternal postnatal depression. The

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researchers carefully examined the data; generated preliminary codes; reviewed, defined and named the themes and finally reported the themes (Braun & Clarke, 2006). Within-case analysis and cross-case analysis were both performed for both the data obtained from the interviews as well as the Delphi evaluations (Bloomberg & Volpe, 2012; Merriam, 2009) .

1.3.7 Ethical considerations.

Ethical approval was obtained from the Health Research Ethics Committee of the Faculty of Health Sciences (HREC), North-West University (Potchefstroom Campus) (NWU-00125-11-S1). This submission follows a strict protocol and covers all aspects of ethical decision-making with regards to research. The promotor assisted in ethical decision-making during the course of this study.

1.3.7.1 Considerations pertaining to postnatal mothers and couples.

Permission to recruit participants at the different institutions: Public and Private Baby Clinics, Hospitals, Private pre-primary schools and crèches in Johannesburg were approached to help identify possible participants. Written permission to recruit research candidates at these various institutions was obtained from these institutions.

Mediators were used to ensure that participants were not pressured to participate in the study: Doctors, nursing staff, midwives, teachers and psychologists were requested to act as mediators in the recruitment phase. Mediators gave parents brochures describing the purpose of the study. Parents who were willing to participate left their details with the mediators and this was then forwarded to the project head.

Possible risks: Participants were informed of the risk that they may become aware of underlying issues that needed to be addressed (DiCicco-Bloom & Crabtree, 2006) whilst

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participating in the semi-structured interviews. Participants who needed support or therapy were referred to qualified therapists in their area.

Possible benefits: The participants had the opportunity to discuss their parenting and PND experiences with a registered clinical psychologist. Participants were informed of the opportunity to participate in the therapeutic intervention after the study had been completed. Participants will be provided with feedback regarding the outcome of this study, this in itself may prove to be therapeutically valuable.

Freedom to withdraw from the programme: Participants were informed that they were free to withdraw from the study at any stage, without stating reasons, and that they would in no way be harmed or penalised by doing so. Participants were also informed that they could request that their data no longer be used in the project.

Confidentiality: All participants were assured of the confidentiality and anonymity of the gathered material. No identifying particulars were used in publications. After completion of the interviews all written material was stored in a cupboard with a lock in a secure office that is locked and has an alarm system. Audio-recordings are stored on computer. All recordings and transcripts on the computer are password protected. Upon completion of the study all documents and confidential material will be stored in a secure office/storeroom at North-West University Potchefstroom campus as per ethical requirements for a period of six years.

1.3.7.2 Considerations pertaining to professionals participating as experts on the Delphi panel.

A mediator was used to ensure that participants were not pressured to participate in the study: For the recruitment of experts an objective mediator was requested to liaise with professionals in the field to request their participation as expert panelists. Experts were also

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invited to ask any questions or request additional information prior to agreeing to participate in the study.

Possible risks: Experts were informed of the risk that their involvement may require time and effort as well as the commitment to deadlines, which could be experienced as burdensome by a professional in full-term employment. The participants were encouraged to speak to the project head if they encountered any problems whilst participating in this study. Participants who suffer from burnout or battle with high levels of stress were informed that they could be referred to a therapist for assistance. Participants were informed that if they themselves have suffered from Postnatal Depression they may become aware of aspects that might require therapy and that a referral could be made to a healthcare professional. Finally, experts were informed that they would not be compensated monetarily and that participation was completely voluntary.

Possible benefits: Experts had the opportunity to participate in a virtual brainstorming activity with other professionals with extensive experience in the field. Experts could also benefit by adding to the knowledge-base of a field where they are actively involved in. Furthermore, an indirect benefit involves assisting in finding more effective means of treating PND, thereby helping to combat the devastating effects of PND on families.

Freedom to withdraw from the programme: Experts were informed that they could withdraw from the study at any stage, without being penalised by doing so. Experts were also informed that they could request that their expert input no longer be used in the project.

Confidentiality: All participants were assured of the confidentiality and anonymity during the Delphi process. No identifying particulars were used in the feedback sent to experts in the second Delphi round. The project head was however able to link names to expert input in order to enable follow-up or clarification of contributions. All electronic material is password protected. Upon completion of the study all documents and confidential

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material will be stored in a secure office/storeroom at North-West University Potchefstroom campus as per ethical requirements for a period of six years.

1.4 Outline of the study

Section A includes a general introduction pertaining to postnatal depression. This is followed by the problem statement that includes the rationale for exploring maternal postnatal depression as experienced by couples.

Section B includes author guidelines as set out by the different academic journals that were identified for publication, followed by the article submitted to the specified journal.

Journal 1: *Health Care for Women International*

Manuscript 1 (B1): Couples' experience of maternal postnatal depression

Journal 2: *International Journal of Mental Health Promotion*

Manuscript 2 (B2): Experts' opinion on a proposed integrative parenting programme for postnatal depression: A Delphi study

Journal 3: *Journal of Contemporary Psychotherapy*

Manuscript 3 (B3): *Building Blocks: A parenting programme for couples experiencing maternal postnatal depression*

Section C includes a reflection regarding the current study, and finally the reference list is outlined.

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SECTION B: JOURNALS, AUTHOR GUIDELINES AND MANUSCRIPTS

SECTION B: ARTICLE 1 (B1)

**COUPLES' EXPERIENCE OF MATERNAL POSTNATAL
DEPRESSION**

To be submitted to

Health Care for Women International

2.1 Guidelines for authors

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References

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2.2 Manuscript: Couples' experience of maternal postnatal depression

Journal word allowance: 6500

Article wordcount: 6707

Couples' experience of maternal postnatal depression

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Abstract

Researchers explored a group of South African couples' experience of maternal postnatal depression (PND), in order to learn about maternal PND as experienced by both partners, as well as to understand the challenges that goes with PND from the couples' perspective. Semi-structured interviews were conducted with 13 couples. Data was analysed thematically and highlighted a significant physical, psychological and interpersonal impact on the family system. Female and male partners have different perceptions regarding the parenting experience and the challenges they encounter, which affect how well they are able to cope with their roles and responsibilities, and also how much support they offer to their partner.

Couples' experience of maternal postnatal depression

Pregnancy and childbirth are both generally considered to be a time of celebration, excitement and joy (Mulcahy, Reay, Wilkinson, & Owen, 2010). However, many parents struggle to deal with this major transition (Roehrich, 2007) due to being unprepared for the personal, social and environmental adjustments (Churchill & Davis, 2010). This demanding period could leave vulnerable individuals at risk of developing mental health difficulties (Mulcahy et al., 2010).

Postnatal depression (PND) is a prevalent non-psychotic depressive illness that presents in the months following childbirth (American Psychiatric Association [APA], 2013) due to a combination of hormonal changes (Melrose, 2010; Yim, Tanner Stapleton, Guardino, Hahn-Holbrook, & Dunkel Schetter, 2015), and personal and social factors (Figueiredo & Conde, 2011; Miles, 2011; Wiklund, Mohlkert, & Edman, 2010). In the DSM-5 it is categorised with other mood disorders as a specifier “with perinatal onset” (Serati, Redaelli, Buoli, & Altamura, 2016). Distinct differences have, however, been noted between PND and other mood disorders. These include excessive fear for the infant’s wellbeing, feeling overwhelmed being alone with the infant, intrusive thoughts of harming the infant and significant levels of irritability and anxiety (Beck & Indman, 2005; Ray, 2014). According to Hunt (2006), the term postnatal depression is misleading as often mothers do not present with depression as the primary complaint, but rather report anxiety or obsessional thoughts. Other symptoms include: low mood, panic attacks, constant fearfulness, tearfulness and oversensitivity, uncontrollable temper tantrums, agitation, feeling out of control, lacking confidence, poor self-esteem, lack of sleep/rest, being exhausted, low libido, forgetfulness and poor functioning overall (Morrissey, 2007; Peltzer & Shikwane, 2011).

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The impact of PND is not only experienced by the mother, but spills over onto the family system as a whole (Mulcahy et al., 2010; Ray, 2014). Parents who are depressed may lose interest in daily activities or interpersonal relations, become withdrawn and isolate themselves, experience problems with regards to emotional and physical intimacy (Dalfen, 2009; Dennis, Janssen, & Singer, 2004; Dennis & Ross, 2006; Miles, 2011; Morrissey, 2007; Page & Wilhelm, 2007; Seymour, Giallo, Cooklin, & Dunning, 2014; Zauderer, 2008); and find it difficult to give or receive support or to create a nurturing environment for their baby (Glavin, 2012). The combination of depression and an unhealthy parental system could have a potential harmful impact on both parents and their children (Ramchandani et al., 2011).

There is limited research regarding fathers' experience of maternal PND (Beestin, Hugh-Jones, & Gough, 2014; Davey, Dziurawiec, & O'Brien-Malone, 2006; Goodman, 2008). Furthermore, there is a gap in the research regarding couples' experience of maternal PND. The researchers could only find one article focussing on the couple's experience of PND, namely the study by Everingham, Heading and Connor (2006) which concentrates on the disruption of communication as a consequence of PND and the couple's inability to support each other due to each one's lack of understanding of the other's experience. The aim of this study was thus to explore the experience of a group of South African couples where the mother suffers from postnatal depression.

Research Design

The research design is qualitative, exploratory and descriptive in nature. Case studies were explored in depth, in order to gain new insight into PND (Denscombe, 2014); to provide a detailed account of PND within the context it presents (Willig, 2008); and to highlight the complexities of PND as well as the participants' understanding of it (Bloomberg & Volpe, 2012; Rossman & Rallis, 2012; Vaismoradi, Turunen, & Bondas, 2013).

Research Method

Ethical Considerations

Ethical clearance was obtained from North-West University, South Africa (NWU-00125-11-S1). Written permission was obtained from those institutions from which participants were recruited from. Participants signed a consent form detailing the nature of the study, as well as their right both to confidentiality and to withdraw from the study. Participants were informed that their participation might evoke feelings and thoughts that require professional assistance. Those participants who presented with a need for support or therapy beyond the study were referred to qualified psychiatrists and psychologists.

Research Sample

Purposive volunteer sampling was used to recruit participants, with the aim of gaining a good understanding of the research phenomena (Bloomberg & Volpe, 2012; Merriam, 2009). The sample included 13 multiparous South African couples, where the mother met the criteria for depression on the Edinburgh Postnatal Depression Screening Scale (EPDS) (Cox & Holden, 2007) within 12 months postpartum. The EPDS is a widely used and validated self-report questionnaire (for both men and women), to screen for postnatal depression (Edmondson, Psychogiou, Vlachos, Netsi, & Ramchandani, 2010; Ramchandani, O'Connor, Heron, Murray & Evans, 2008) and has been validated for use in South Africa (De Bruin, Swartz, Tomlinson, Cooper, & Molteno, 2004). Participants had to be proficient in English due to the screening scale that was used. Parents with a recent history (since the birth of the lastborn) of depression not related to the pregnancy were excluded to preclude the possibility of pre-existing depression. The couples come from varying socio-economic circumstances.

Data Collection

Couples' experience of postnatal depression was explored by means of semi-structured interviews. Interviews complied with the guidelines set out by Merriam (2009): There was a combination of structured and semi-structured questions; questions were used flexibly; specific data was required from all participants; the interview was guided by the research topic; and there was no predetermined wording or order to the questions. The content of the semi-structured interviews was informed by a thorough analysis of the relevant literature. Participants were interviewed as a couple at a venue that was convenient to them. Interviews were audio-recorded.

Data Analysis

Thematic data analysis was employed in order to define, explore, extract and report themes within data (Braun, Clarke, & Terry, 2015; Clarke & Braun, 2013), in order to gain a thorough understanding of the experience and meaning participants attach to their experiences (Bloomberg & Volpe, 2012; Braun & Clarke, 2006). The data gathered was used to enhance the existing knowledge obtained from the literature analysis.

As per the guidelines of Braun and Clarke (2006), the researchers familiarised themselves with the data; generated initial codes; searched for themes within the coded data; reviewed the themes; defined and named themes; and lastly themes were reported. Detailed descriptions of each case were provided (within-case analysis), thereafter cross-case analysis was performed (Bloomberg & Volpe, 2012; Merriam, 2009).

Findings

The data highlights the complex interaction between the physical, psychological and interpersonal experience of the person diagnosed with PND and the partner as well as the systems they are a part of.

Physical Experience

Lack of sleep.

Effect of lack of sleep on emotions. Mothers (M#4,7,9&10) reported insufficient sleep and ruminating thoughts that lead to stress and anxiety. One participant (M#9) explains “I cannot sleep, you are always worried...”, and mothers (M#2,3,6&9) experience panic due to insomnia. For mothers (M#8&9) lack of sleep contributes to frustration, anger and hostility, while mother (M#12) experiences irritability and feels overwhelmed when she is tired “Sleep deprivation is a big thing that will trigger it...”. Fathers (D#8&9) reported insomnia due to stress, but only two fathers (D#7&13) reported mood disturbance due to lack of sleep.

Effect of lack of sleep on coping. Most mothers (M#1,4,7,8,9,10,12&13) reported that it is far more difficult to cope with daily demands when feeling tired and drained. Fathers (D#1,7, 9&13) get upset when their children wake them as they know this will affect their energy at work.

Low energy levels.

Both mothers and fathers reported low energy levels. Mothers’ (M#1,4,6,7,8,10,12&13) lack of energy seems to be related to childcare. Mother (M#13) explains that she is “permanently tired...” and states that she has more energy at work than at home. For fathers (D#1,4,6,7&8) lack of energy is work-related, many of the fathers in the

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sample are sole providers. Father (D#1) states “I’m always tired due to working late hours”, while father (D#6) agrees “...my energy is lower than usual because of work...”.

The use of medication.

Over-the-counter medication. Participants (M#1,2,5,7,8 &12) use over-the-counter medication to help them cope with depression and anxiety. Mother (M#5) states “I take Allergex to help calm my mind”, while mother (M#8) uses Tissue Salts for anxiety, mother (M#2) finds the use of a supplement beneficial and mothers (M#1,7&12) use Rescue Remedy. Mother (M#12) shares her experience: “I have had like Rescue tablet moments...where I would just like pour the bottle into my mouth”. When she gets overwhelmed she tries to calm herself as well as her infant, she explains: “...once it is soft enough I’m just like transferring the Rescue into (infant’s) mouth so that we are like both calming down”.

Prescription medication. Nine female participants have taken prescribed treatment for anxiety or depression. Non-compliance and medication misuse emerged as themes. Participant (M#10) did not take the medication long enough to experience its benefits, while mothers (M#3&12) stopped the medication without consulting with their doctors. Only one father (D#13) uses prescription medication for depression.

Psychological Experience

The role of personality traits.

All but two mothers present with personality traits that make it difficult to deal with the multitude of challenges surrounding childcare. These traits include: a need for control, a constant sense of urgency, being easily provoked and self-critical; and seem to be exacerbated by PND. Mother (M#13) explains “I am a very structure orientated person, I am

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even worse now, more of a pain”; while mother (M#7) states “I am prone to see things from a negative perspective, if one of them get sick...to me that is a train smash”. Most of the fathers in the sample seem to have a more carefree personality, as father (D#7) explains “...I deal with things as they come...”. These personality differences lead to tension in couples’ relationships (C#4,5,8&13) as some mothers perceive their partners’ as being unsupportive during a time that the former are struggling to cope.

Emotional manifestation.

Fluctuation in mood. Mood fluctuations were reported by mothers (M#1,2,5,6,9&12). For mother (M#9) these fluctuations are rapid “...It is changing ... From happy, ... I just get sad, emotional and cry, it just switch like that. I get very angry”. Others reported being more sensitive (M#2,4&8). Mother (M#2) explains “Little things can trigger strong emotions...” and “... I take everything personally” (M#8). Only one father (D#13) experiences significant mood fluctuations, while husbands (D#2,4,5&10) feel negatively affected by their wives’ moods. Father (D#5) mentions “...I have felt depressed, but I think it is her depression that spills over onto me”.

Emotional exhaustion. Mothers (M#7,8&12) feel emotionally drained. Mother (M#7) explains “Sometimes it feels as if I just don’t want to give another piece of myself...”. For mother (M#8) the physical and emotional strain impacts on her relationship with her husband, and she says “... I am still breastfeeding that little one, he is constantly with me, ... , and then the firstborn... it is ‘Mommy I am hungry’ or ‘Mommy I am thirsty’, and by the time my husband comes home I am so tired of doing ‘Mommy, Mommy ‘ that there is nothing left to give”. Emotional exhaustion did not emerge as a prominent theme among the men in the sample.

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Feeling overwhelmed. Unceasing demands and perceived limited resources both cause many mothers to feel overwhelmed. Mother (M#7) can “never relax” and mother (M#1) mentions that “... everything feels too much”, while mother (M#10) feels very stressed “... I feel like maybe...I am losing my mind” and mother (M#13) feels overwhelmed by being alone with her children “...I have to say honestly, I cannot always cope with that”. Basic chores cause mother (M#12) to “spiral into this stress ball”, “just seeing the dishes would send me into a complete meltdown, because I didn’t know where to start first”. She struggles to enjoy playtime with her children “... It is so stressful, seeing that amount of LEGO”. Couple (#7) become overwhelmed by a messy environment and high noise levels and mother (M#7) explains “...the chaos gets to you”. Fathers (D#1&13) also get overwhelmed by too much noise, father (D#13) states “...the noise levels in the house is unbearable...”.

Some mothers (M#1,4,7&12) expressed the desire to escape from their circumstances. Mother (M#7) explains “I’m going to get into the car and just drive, like just leave the children here and never return”, and mother (M#1) adds “I want to quit or resign from the kids and my marriage. It is really no pleasure”. Mother (M#4) has felt very desperate “I have felt it was a mistake to have kids. I have suggested to my husband that we should put our eldest up for adoption”. Fathers in the sample did not express the fantasy to escape, but this could be because the physical means of escape is available to them more so than to the women in the sample in the form of work, sport etc.

Feelings of irritation and frustration. Mother (M#12) explains that due to feeling irritable “...I have noticed that mostly with my husband and obviously my children, that I would be very critical...”. For mother (M#8) irritation turns into aggression “I feel a lot more irritable I almost want to say aggressive”. Mothers (M#1,7,8&13) report feelings of frustration that are related to the added responsibility, constant demands and the limitations

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that go with childcare. Mother (M#1) explains that it is “frustrating having to meet everyone’s needs”, while father (D#8) mentions that isolation leads to his wife’s frustration. A small group of fathers (D#1,3&8) reported feelings of frustration regarding work and being the sole provider.

Feelings of impatience. Several mothers (M#3,4,7,8&12) struggle with impatience. Mother (M#12) finds that her impatience is a result of stress, and she says “...He’s like a little free soul, but when I am in that stressed state, I have zero tolerance for it”. For others impatience results in feelings of guilt, as mother (M#4) explains: “My levels of patience are exhausted; I do and say things I later regret”. Only one father (D#3) reported being impatient.

Feelings of anger. Anger emerged as a common theme. Mothers (M#5,7,8,9,10&13) reported experiencing excessive anger. Mother (M#9) explains, “I get angry so easily, ...I just go off”, while mother (M#8) adds “it is as if I am going to explode at any moment and I am not like that”. Anger results from the perceived inequalities in the burden of childcare. Mother (M#5) states “I blame my husband a lot for having kids when he is not helping”, and for mother (M#7), because her needs are always secondary to the needs of her children, “...then she wanted my chips and I flipped because I hadn’t eaten the whole day...”. Fathers (D#6,7&8) reported having a short temper and one father (D#13) mentioned that he gets angry more easily than before.

Feelings of depression. As expected nearly all the female participants (M#1,2,3,4,6,8,9,10&12) reported having experienced symptoms of depression. For mothers (M#1&4) the symptoms started during the puerperal period and mothers (M#3&12) reported that they had been diagnosed with PND more than once. A small group of fathers (D#5,9 &13) reported symptoms of depression. Two of these fathers have been diagnosed with depression, while the third experiences depression due to financial stress. Husband (D#5) feels his depression is related to his wife’s emotional difficulties.

Feelings of anxiety. The majority of mothers (M#1,2,3,4,5,6,9&12) reported experiencing anxiety. Mothers who worry by nature reported that their anxiety became much worse, and mother (M#4) states “My worries are over the top, drastically more than before I had children”. For mother (M#5) the anxiety started during her pregnancy as a result of an earlier miscarriage, while mother (M#6) states that her anxiety was triggered by distressing thoughts about what would happen to her children if she and her husband happened to die. She mentions that, once the anxiety was triggered, it never went away. At times the anxiety triggers panic attacks, mothers (M#2&3) also experience panic attacks. Both mother (M#12) and couple (C#6) experienced the anxiety symptoms as being extremely traumatic, and father (D#6) explains “... the anxiety was worse even than the time when our lastborn was basically fighting for her life”. Feelings of anxiety were not a prominent theme among most fathers in this sample.

Feelings of guilt and regret. Guilt and regret emerged as prominent themes. Mother (M#4) defines a parent as a “bag of guilt”. This “bag” contains guilt regarding impatience (M#3&12), getting angry and saying things without thinking (M#4,5&12), having emotional outbursts (M#9), disciplining the children (M#5), possibly favouring one child above the other (M#6&8), neglecting duties and relying on partners to take on more responsibility (M#3&4), asking for help (M#8) and having needs or ambitions other than those related to being a parent (M#6). Mothers feel guilty for the impact their emotional struggle might have on their families, as explained by mother (M#5) “I have guilt feelings about the possible damage I may do to my kids”. None of the fathers reported feelings of guilt or regret. This is likely because many fathers in this sample (D#1,4,6,7&10) avoided the role of disciplinarian, which could add to the emotional burden of the mother who is already battling to deal with her emotions.

Cognitive challenges.

Concentration and memory. Several mothers struggle to concentrate and experience memory difficulties. Mother (M#3) tells how "...there was a void in my head, ... I was extremely forgetful", while mother (M#5) needs cues to remember: "I put messages on my phone to remind myself and I keep repeating things...". For some mothers, memory deficits result in anxiety, and mother (M#12) says "...I felt like my brain was failing me, like I couldn't think properly. It was the scariest thing, I felt like I was losing my mind...". Fathers also experience cognitive challenges, thus, father (D#2) states that he is forgetful, while father (D#9) is absent minded and father (D#13) mentions that his memory is affected by sleep deprivation.

Negative self-concept.

Negative self-evaluation. The majority of mothers reported low self-esteem. Mother (M#7) measures herself against her peers and feels inadequate. Participant (M#2) experiences a loss of identity, and she explains "Before being a parent I was sure of what I was doing. I was sure about myself and confident. Now I am always questioning myself". Others feel pressure from perceived expectations of society. Mother (M#8) states "My self-esteem, ..., is not great ... I don't work, I just look after the children", while Mother (M#5) feels judged firstly for struggling to conceive and also for developing depression, and so she says "People make you feel like you are not normal for not having kids and then you are not normal for struggling when you do have kids", whilst mother (M#6) feels very embarrassed about the fact that she struggles with her emotions. She states "...It sounds so pathetic...how weak are you!".

The fathers in this sample seem to have an opposite experience. Fatherhood boosts many fathers' self-esteem, as father (D#5) mentioned when asked about his role as father: "I

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feel proud and confident. It (fatherhood) made me bolder, broke my sense of inferiority...”, while father (D#12) has a similar view and states that his “...self-belief is a lot higher”.

Negative evaluation of the self as parent. Mothers (M#1,2,4,5&8) doubt their parenting abilities, as explained by mother (M#1): “... it feels as if I don’t know what I am doing”. Participant (M#6) doubts her ability to keep her children safe, while mother (M#12) fears “that I’m not mentally, emotionally able to be that nurturer that they need”. Some mothers judge themselves according to their own expectations. Mother (M#3) says “A lot of time I feel I can do better” and others according to the presumed perceptions of others, and mother (M#8) explains “I worry what people think...if I compare him to the other children..., then I think, but am I a good mother?”.

Concerning the evaluation of the self, fathers (D#3,7&9) seem to have a healthier outlook regarding their parenting abilities. Father (D#9) states that he is “...very proud of the father I have become”, and father (D#3) describes parenting as an “adventure”; and he seems to find his role very rewarding.

Interpersonal Experience

Impact on the intimate relationship.

Disengagement. Parents report difficulty connecting with their partners, and many couples ascribe this to the fact that their children require all their time and attention. Fathers (D#1,2&7) and mothers (M#4&5) agree that “...you have no time to do anything else but parent” (D#1); mother (M#6) explains that her husband is “...no longer number one focus...” and father (D#7) mentions that it is obvious that “your marriage will suffer”.

Disengagement also seems to result from poor communication as indicated by couples (C#1,2,3,7,8,9&10). Fathers (D#2,3&7) state that they withdraw in order to avoid stress,

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while father (D#9) struggles to communicate and avoids interacting with his wife by playing games on his phone.

Feelings of isolation. Many fathers (D#1,2,5&9) experience limited support. Father (D#2) mentions that he felt very alone when his wife was ill and he had to take over all the childcare responsibilities, while mothers (M#6&10) feel neglected. Mother (M#10) explains, “He doesn’t even have time for us” and mother (M#1) feels lonely because her husband is “...emotionally unavailable”.

Conflict. Couples experience increased conflict. Mothers (M#4,8&13) get upset with their partners for not taking their parenting role seriously. Mother (M#2) complains that she does the hard work while her husband is only involved in the fun activities. Mothers (M#4&12) also feel upset about perceived role inequalities. Both these mothers work fulltime, while mother (M#8) feels that her role as stay-at-home mother enables her husband to have his needs met while she has to sacrifice some of her interests. Some mothers get upset when their partners engage in activities that do not involve childcare. Mother (M#7) gets angry when her husband “escapes” by doing other tasks such as cleaning the pool, while father (D#9) explains that his wife gets upset when he wants to unwind after work and he says “...I am tired, I’m feeling like not talking then I just go to my phone, playing games, (she feels) like I am avoiding them”.

The lack of availability and use of support.

Lack of support within the relationship. Depression in one partner limits the emotional and practical resources that are available to the rest of the family. Fathers (D#2,3&4) took on the role as primary caregiver whilst their wives struggled to cope. The depressed individual may require a great deal of support and the healthy individual might struggle to provide continuous support. Husband (D#7) tends to withdraw when his wife is

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struggling emotionally: "... if it gets really difficult, ... I become a bit detached", while mother (M#10) becomes upset with her husband for this exact reason, and she says: "...He does not talk to me... sometimes I feel like he is not there for me...". Mother (M#1) feels alone; she explains, "I don't feel that he understands what I am going through". Father (D#5) also reports feeling alone, "I miss her support...", while couple (#7) finds it difficult to support each other: "It is difficult ... when both are feeling overwhelmed" (M#7). Many fathers (D#1,6,7,8,9&10) have difficulty managing the roles of being both parent and sole provider.

Lack of support from family and friends. External support is not always available as couples tend to become socially isolated. This seems to be related to depression, anxiety, exhaustion and childcare routine. Mother (M#1) does not engage socially, she says "...I don't make an effort with my friends anymore". Mother (M#3) avoids social situations, and she states "...I get panic attacks and then we have to go...", while mother (M#8) explains that she cannot relax when they visit friends or family. "...The whole time you are thinking, the children have to eat, they will not behave, ... they have to sleep at a certain time...". Mother (M#9) states that her family has not supported her during this trying time and mother (M#8) feels she cannot reach out to her mother as the latter worries too easily. Couple (#5) also feels unsupported by their family "...We had difficulty with people not believing that there was something wrong with her" (D#5).

Lack of professional support. Some couples (C#4,6,9) felt very disappointed in the health system, and father (D#6) states "...Finding help was exceptionally difficult". Mother (M#4) felt let down by a crisis centre: "I phoned the hotline and held the line for 10 minutes, they only returned my call 24 hours later..." Lack of information, resources and time prevents couples from getting the help they require. Mother (M#9) shares "...We wanted to go for counselling, ... we didn't know where to go, or is it going to be expensive...".

Support groups. Most mothers (M#1,3,5,6&8) who reached out to support groups found this beneficial; mother (M#5) explains "...being part of these groups normalised my experiences, made me realize I was not alone". Husband (D#6) felt the support group was the most helpful in his wife's healing, saying "...the group she joined, where she could talk a bit, that was almost the best...". Mothers (M#2&12) struggle to find time to attend groups. Mother (M#12) mentions "I stopped going due to returning to work, ... it is just another thing to try and absorb into your day...", whilst mothers (M#1&4) feel too exhausted to attend groups. None of the fathers in the sample reached out for organised help.

The use of support. Some mothers really struggle to reach out for help, and this seems to be related to the stigma attached to mental health difficulties. Mother (M#8) states "...sometimes I will pretend as if nothing is wrong..."; also because of resistance: "I wanted to do it by myself, there must be a way I can sort myself out..." (M#12), and denial "... You are in denial, because you don't want to believe it can happen to you..." (M#6).

The experience of resilience and fulfilment.

Finally, a strong theme of resilience emerged from the data. Some couples feel the PND experience has strengthened their relationship. Mother (M#5) explains "We have to rely on each other more", and regardless of the challenges, parents really seem to enjoy their children. Fathers (D#8&9) enjoy activities with their kids and teaching them new things, and fathers (D#3,9&12) report that parenting brings balance to their lives, as father (D#12) explains, "The kids can make everything else go away, and it helps you to find perspective". Mothers (M#2,5,9&12) report themes of life enrichment; for mother (M#5) being a mother feels like an "achievement", mothers (M#12&2) describe "...my life is 100 fold better now than it ever was before" (M#12), and "My children have opened up my eyes to what life is all about..." (M#2); and increased happiness in a very trying time in the couple's lives. Mother

(M#9) explains "...at the end of the day the kids put a smile on your face; they bring happiness in the house...".

Discussion

Many couples dream about having a family (Carneiro, Corboz-Warnery, & Fivaz-Depeursinge, 2006; Krieg, 2007; Nicolson, 2001). A significant number of couples, however, experience a deterioration in their relationship in the first years of parenthood (Condon, Boyce, & Corkindale, 2004; Schulz, Cowan, & Cowan, 2006), with increased reports of depression during this period (Goodman, 2004; Matthey, Barnett, Ungerer, & Waters, 2000). The impact of PND is experienced by the whole family system and manifests on a physical, psychological and interpersonal level.

Physically, participants experience a lack of sleep and energy. Fatigue is part of the normal adjustment when becoming a parent, and what contributes to PND is the fact that the exhaustion is persistent (Corwin, Brownstead, Barton, Heckard, & Morin, 2005) during a time where parents are emotionally and physically drained. Most mothers in this study use over-the-counter or prescription medication to cope with PND, yet themes of non-compliance and medication misuse emerged from the data.

Psychologically, personality traits emerged as a vulnerability factor in the development and maintenance of PND, while PND seems to exacerbate these traits. Many mothers present with anxiety or neuroticism (Milgrom, Ericksen, McCarthy, & Gemmill, 2006; Robertson, Grace, Wallington, & Stewart, 2004), perfectionist traits, a need for control, excessive worry and they are also easily upset or overwhelmed (Dalfen, 2009; Milgrom et al., 2006; Rode, 2016). Female participants in this study reported mood fluctuations and being emotionally exhausted. Both male and female participants indicated the constant demands as being one of the most overwhelming aspects of parenting and

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mentioned that problems that they were able to deal with prior to the arrival of their baby feel too difficult to manage, and this is in line with research by Yim et al., (2015). Many mothers expressed the wish to escape from their circumstances. Being overwhelmed could lead to feelings of frustration, anxiety, and depression (Venis & McCloskey, 2007). Participants in the sample additionally reported irritability, impatience and anger. Mood fluctuations often result in hostile behaviour and subsequent feelings of guilt. Guilt was reported by mothers concerning the impact of the difficulties they experience on their families. Another psychological factor relates to cognitive challenges, where both mothers and fathers reported memory and concentration difficulties. According to Bernstein et al. (2008), mothers who suffer from PND often present with impaired concentration and decision-making abilities, while fathers' cognitive abilities seem to be negatively impacted by their partner's PND. Finally, with regards to the psychological experience, many mothers in the sample perceive themselves in a negative light and doubt their parenting abilities, and this makes them more susceptible to develop PND (Beck, 2001; Dennis & Hodnett, 2007; Lee & Chung, 2007; Leigh & Milgrom, 2008; Milgrom et al., 2006; Nonacs, 2006). Fathers on the other hand appeared to have healthier self-esteem and beliefs about their parenting abilities.

On an interpersonal level, couples are faced with a simultaneous disengagement, but also a stronger demand for emotional and practical support. A lack of information about PND could result in the healthy partner withdrawing support and investing more time outside the home environment (work, sport etc.) (Everingham et al., 2006; Shapiro & Gottman, 2005). This could widen the distance experienced in the relationship, lead to feelings of isolation and loneliness, increase the disproportions in parenting responsibilities and result in greater discord (Iles, Slade, & Spiby, 2011; Nonacs, 2006). Several male participants reported being negatively affected by the emotional difficulties of their partners. This limits the emotional and practical resources available for the couple to support each other and provide a nurturing

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environment for their children (Dennis & Ross, 2006). External support could also be limited due to time constraints, limited mobility and couples withdrawing and isolating themselves (Alici-Evcimen & Sudak, 2003; Dennis & Hodnett, 2007; Patel, Wittkowski, Fox, & Wieck, 2013). Some mothers feared being stigmatised as weak or incapable of taking care of their children and therefore did not seek help. Couples expressed frustration and disappointment in the healthcare system as many battled to find help when they needed it. Few mothers or couples reached out for help in the form of counselling, but some joined support groups and many found this form of support helpful.

A strong theme of resilience emerged from the data, in that most couples felt that having children has enriched their lives and that despite the challenges, their children make everything worthwhile.

Conclusion

Each couple in this study had a very unique parenting experience, but shared characteristics that made them vulnerable to develop emotional difficulties. Mothers and fathers have different perceptions about parenting roles and responsibilities as well as their ability to raise children. Men in this study do not relate to the emotional struggle of their partner. This limits the quality of support they are able to offer and leaves mothers feeling unsupported. All these factors mentioned would be amenable to therapy.

Recommendations

Given the impact of PND on the individual, couple and greater family system, it is recommended that an integrative parenting programme be developed to enhance the couples' coping skills and aid in alleviating depressive symptoms.

Limitations

Owing to a small sample size the results of this study cannot be generalised. The group lacked adequate cultural diversity and did not control for different socio-economic levels; this would have a definite impact on the parenting experience. The interviews were lengthy which often caused participant fatigue.

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**Experts' opinion on a proposed integrative parenting programme for
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2.4 Manuscript: Experts' opinion on a proposed integrative parenting programme for postnatal depression: A Delphi study

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**Experts' opinion on a proposed integrative parenting programme for
postnatal depression: A Delphi study**

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Abstract

Due to the vast impact of postnatal depression (PND) on the individual, as well as on the system of which this individual is a part, continuous research is essential in finding effective intervention methods. The researchers aimed to develop a parenting programme for couples who experience maternal postnatal depression. This article reports on the evaluation of a proposed programme using the Delphi method, with the aim of refining and enhancing the quality of the programme. A pure qualitative Delphi method consisting of 2 rounds of evaluation was used for this study. Ten experts from different mental health disciplines commented on the structure, content, process, strengths, limitations and foreseeable challenges of the proposed programme. The experts provided recommendations to enhance the programme. These recommendations will guide the refinement of the proposed intervention programme.

Keywords: Postnatal depression; couple; proposed intervention; Delphi method; evaluation

Introduction

The arrival of a baby brings about a major shift in the family dynamics (Carneiro, Corboz-Warnery, & Fivaz-Depeursinge, 2006; Krieg, 2007; Nicolson, 2001) and couples are often unprepared for the significant personal, social and environmental changes that parenting demands (Churchill & Davis, 2010), leaving them at the risk of increased relationship difficulties (Misri, 2006; Shapiro & Gottman, 2005). Nonetheless, few parenting programmes prepare couples for the adjustment post birth (Schulz, Cowan, & Cowan, 2006; Shapiro & Gottman, 2005) or for the possibility of the development of postnatal depression (Roehrich, 2007).

Approximately 13-19% mothers experience depression within twelve months postpartum (O'Hara & McCabe, 2013). Postnatal depression (PND) is marked by symptoms of persistent emotional and psychological distress (Morrissey, 2007), last for more than 2 weeks postpartum and impairs daily functioning (Robertson, Grace, Wallington, & Stewart, 2004; Venis & McCloskey, 2007). It occurs when substantial demands are being made on the family's resources and infant development is at a critical stage (Cox & Holden, 2007; Oates et al., 2004).

Programmes that were found to be effective in treating PND include the *EPIC* programme (Bultjens, Robinson, & Liamputtong, 2008), the *Mellow Babies* programme (Puckering, McIntosh, Hickey, & Longford, 2010), which focus solely on the mother and infant, and *The Getting Ahead of Postnatal Depression* programme (Milgrom, Martin, & Negri, 2006b) that includes optional partner sessions. Research, however, highlights the importance of including both parents in interventions (Iles, Slade, & Spiby, 2011). Furthermore, relationship discord and poor partner support are some of the strongest predictors of postnatal depression (PND) (Clatworthy, 2012; Dalfen, 2009; Dennis & Ross, 2006; Grigoriadis & Ravitz, 2007; Milgrom, Ericksen, McCarthy, & Gemmill, 2006a;

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Mulcahy, Reay, Wilkinson, & Owen, 2010; Venis & McCloskey, 2007). The comorbidity of parental depression and marital conflict could potentially have a harmful impact on the whole family system (Ramchandani et al., 2011).

The *Bringing Baby Home* (BBH) programme (Gottman, Shapiro, & Parthemer, 2004), is a weekend sixteen-hour, psycho-communicative-educational workshop for both parents. It has 3 treatment goals: strengthening the marital bond; facilitating both parents' involvement in childrearing; and psycho-education with regards to child development and parenting. An added benefit was that mothers suffering from depression experienced symptomatic relief (Gottman, Shapiro, & Parthemer, 2004). An explorative study of the BBH programme (Buzzard-Speights, 2013) indicates that the length of sessions overwhelms participants and facilitators themselves feel overwhelmed by the volume of workshop preparation. Furthermore, couples could not relate to content on postnatal depression (Buzzard-Speights, 2013), possibly because the target population was not suffering from PND (Gottman, Shapiro, & Parthemer, 2004). A factor that was not addressed by the BBH programme was that of negative cognitions, which is a prominent symptom in parents who suffer from PND (Dalfen, 2009; Leigh & Milgrom, 2008; Seymour, Giallo, Cooklin, & Dunning, 2014; Sword, Clark, Hegadoren, Brooks, & Kingston, 2012) and could alter a person's perception of interpersonal relationships (Wilkinson & Mulcahy, 2010), leading to difficulties in noticing and accepting support. The current researchers believe that, unless negative cognitions are addressed, individuals may not benefit optimally from programme content, as their perceptions may be clouded by negativity. Another aspect that was neglected in the BBH programme was that of the individual needs of parents. According to Puryear (2007), self-care is extremely important in building resilience to cope with parenting demands. Finally, Cowan, Cowan and Knox (2010) criticise the BBH programme for not focussing on strengthening the support structure.

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Studies have advocated for the incorporation of both parents in an integrative holistic intervention (Kane & Garber, 2004; Kathree & Petersen, 2012; Milgrom et al., 2006b; Mulcahy et al., 2010; Paulson & Bazemore, 2010), that could also be tailored to the specific needs of individuals (Hunt, 2006; Solomonov & Barber, 2016). By integrating biological, psychological and social factors into a parenting programme for both partners, the risks involved in the negative consequences of postnatal depression on the family system could be reduced (Kane & Garber, 2004; Reck et al., 2011).

This article reports on the evaluation of a programme developed for couples experiencing maternal PND, using the Delphi method. As far as the researchers are aware, no other South African study has developed a PND parenting programme specifically for couples.

Preliminary programme development

As per the guidelines of the model of Design and Development (D&D) (Thomas & Rothman, 2013), key aspects of the research problem were explored by means of a thorough literature analysis, as well as semi-structured interviews with couples who experienced maternal PND. Findings were reported in a preceding article by Ferreira and Van Rensburg (In review). Themes obtained from the data were used to compile a preliminary parenting programme. The next phase of D&D entails an evaluation of the proposed programme. For this purpose the Delphi method was employed (Skulmoski, Hartman, & Krahn, 2007), drawing from the knowledge of experts treating couples who experience maternal PND, with the aim of refining the programme.

Brief outline of the proposed programme as presented to the Delphi panel.

The proposed programme is to be offered over 7 sessions of approximately 2 hours each and covers 6 modules. Groups are 'closed' and accommodate 5 couples at a time. The first session is an information session to allow for introductions and orientation and includes a discussion on the myths of parenting. This is followed by 5 sessions for couples. These sessions focus on the challenges of parenting; providing parents with psycho-education concerning PND and the available treatment options; the impact of negative cognitions on the development and maintenance of depression; the importance of good self-care in building resilience to cope with parenting demands; the importance of a supportive relationship with the intimate partner, the essentials in creating a supportive relationship, as well as ways partners can support each other during this challenging period; and finally ways of fostering healthy parent-infant attachment. The programme ends with a practical parent-infant session where both parents are empowered to provide warm, attentive care to their infant.

Method**Design**

The Delphi technique is a widely used and accepted qualitative research method, developed by Dalkey and Helmer (Hsu & Sandford, 2007; Skulmoski et al., 2007). It resembles a virtual brainstorming session (Okoli & Pawlowski, 2004), with the aim of gathering reliable opinions from experts in the field of interest (Landeta, 2006). It stimulates confrontation and communication, without the interference of group dynamics (Ter Haar, Aarts, & Verhoeven, 2016) as experts remain anonymous in their feedback (Landeta, 2006; Okoli & Pawlowski, 2004; Skulmoski et al., 2007). Experts have a consultative role and differences in opinion are welcomed and explored (De Villiers, De Villiers, & Kent, 2005).

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The process normally consists of a series of 2 or more questionnaires (Iqbal & Pison-Young, 2009) interspersed with a summary of expert opinions (Skulmoski et al, 2007).

Ethics

Ethical clearance was obtained through North West University, South Africa (NWU-00125-11-S1). Participants for the Delphi panel signed a consent form detailing the nature of the study, inclusion criteria, requirements of participants, as well as their right to confidentiality and the right to withdraw from the study.

Participants

A research mediator extended invitations to participate as Delphi experts to sixty-three professionals from different mental health disciplines. Inclusion criteria encompassed: an interest, knowledge and experience in the field of PND; registration with a professional regulatory board; at least 2 years of professional experience consulting with mothers who suffer from PND; and sufficient time to commit to the Delphi process. Fifteen (15) professionals expressed interest upon which the consent document was forwarded to them electronically. Of the fifteen, 4 professionals withdrew due to time constraints or not meeting inclusion criteria, and 1 professional did not return the consent form or respond to further correspondence. The final panel consisted of ten (10) experts including 3 psychiatrists, 3 clinical psychologists, 1 educational psychologist, 2 clinical social workers and 1 professional nurse. Two of the professionals also lecture, whilst another is jointly registered as a research psychologist. This diverse range of professionals allowed for a comprehensive evaluation of all aspects pertaining to the parenting programme. The panel's professional experience ranged between 2 years (specialist practitioner) and thirty-five years. Panel members have weekly or monthly contact with individuals who suffer from PND.

Research Process - The Delphi Method

For the purpose of this study a pure qualitative Delphi method involving two (2) rounds of evaluation was employed, with the aim of seeking input on the quality and content of a parenting programme.

Round 1

A questionnaire and facilitator manual for the proposed parenting programme was emailed to experts. The questionnaire consisted of 2 parts. Part 1 requested information regarding professional experience and experts were asked to comment on 2 open-ended questions:

1. In your opinion what seems to work best in alleviating the symptoms of PND?
2. What are the challenges you have experienced working with people who suffer from PND?

The second part required experts to familiarise themselves with the content of a fifty-seven-page facilitator manual and to comment on its structure and content, and anticipated challenges as well as possible solutions to these challenges. Experts were requested to provide feedback within 2 weeks and were informed that they would be granted an opportunity to view and respond to comments of fellow Delphi experts. Responses were analysed qualitatively by means of thematic data analysis and summarised for the purpose of the second Delphi round. As mentioned, expert names were not linked to comments, in order to encourage open, honest feedback without the pressure of group dynamics (Ter Haar, et al., 2016).

Round 2

A summary of expert responses and a questionnaire based on the summarised data was sent to experts for final review and input. Experts were encouraged to clarify or make amendments to their initial feedback, as well as to comment on input by other professionals. Aspects that experts did not agree on were highlighted in the questionnaire. Experts were given 2 weeks to provide feedback. All but 1 expert returned the second questionnaire. Final comments were analysed and integrated with themes from the first round.

Data analysis

Data from both rounds were explored, coded and ordered into categories (Braun, Clarke, & Terry, 2015; Clarke & Braun, 2013) by means of thematic data analysis. Themes that emerged related to the structure, content, process, strengths, limitations and foreseeable challenges of the proposed programme.

Results

Experts' opinion regarding elements to consider when structuring a programme

Identify the target population.

Experts indicated the necessity of clearly identifying the target population. In this regard expert (3) noted that socioeconomic levels, culture, and race etc., would impact on the relevance of the manual content. Expert (10) added that cultural and educational levels should be kept in mind when planning an intervention as both factors could contribute to the development of PND, and further highlighted that the stage of depression need to be considered when including individuals in groups as mental state could interfere with the ability to engage in groups.

Consider the feasibility of the timeframe.

Programme duration. Experts (1, 2, 6, 7, 8 & 10) expressed concern regarding the length of the programme. Experts (8 & 10) doubt whether parents will commit to a lengthy programme, while 4 experts (3, 4, 5 & 9) state that if the programme is perceived as offering a valuable supportive space, duration would not be problematic. Expert (3) states ‘... if the participants felt supported there wouldn’t be a burn out response but rather an increased commitment’ and expert (4) agrees ‘...if the group becomes their lifeline and their social contact, then 3 months will be manageable’.

Length of sessions. Experts (4, 7, 9 & 10) advised against a lengthy first session. Expert (4) explains: ‘3 hours is a long time for PND mothers to concentrate’, and expert (9) adds, ‘Couples have to find baby sitters etc., they are exhausted, limiting how much they can process’.

Length of modules. Experts (2, 4, 5, 6 & 10) noted that the volume of information might be difficult to manage given time constraints, and mentioned that facilitators might find it difficult to ‘...move between themes’ (10).

Make it easy for couples to attend the programme.

Experts (1, 2, 4, 6 & 10) highlighted childcare, breastfeeding, time limitation and limited social support as aspects that could hinder couples from attending a lengthy programme and recommended the use of childminders.

Identify risk cases at onset.

The importance of screening for risk (i.e. suicide or homicide) and referral to appropriate healthcare professionals was highlighted by experts (1, 2, 6, 7, 8, 9 & 10). The potential need for individual and couple counselling separate to the group intervention was

emphasised and experts (2, 8, 9 & 10) suggest providing participants with a list of community resources.

Experts' recommendation regarding the content of the proposed programme

Be sensitive to context and diversity.

Experts (2, 3 & 10) highlighted the aspect of diversity with specific reference to available resources in different communities saying: 'It may be inappropriate to recommend massage and yoga classes in the context of families living in relative poverty' (2). Expert (8) cautions against generalisations regarding childrearing practices. Expert (10) agreed and noted that some cultures / communities in South Africa do not place emphasis on the father's involvement. In line with this, experts emphasised the value of making content and discussions personal to the experiences of group members as this could facilitate the generation of realistic solutions to problems.

Determine the hierarchy of needs.

Experts could not agree on the order of modules, but most (2, 3, 4, 6, 7, 8, 9 & 10) strongly recommend offering information about medication (module 7) in the first session. Expert (3) explains, 'I always think of medication as the offering of a lifebuoy to help the person in the stormy sea wait for the storm to pass...'. After the second Delphi round, there was still no clear order preference among experts, and expert (4) states that '...it will depend on the group and what they need...' and suggests flexibility regarding the order of module presentation.

Add value, do not add to the burden.

Parents have a lot to deal with, and given the fact that the target group presents with a mental illness; experts emphasised that care should be taken not to add to their distress but to offer couples something useful:

By being flexible and setting achievable outcomes. Experts cautioned against adding expectations that are difficult to meet. Expert (3) noted, ‘This module requires of participants that they engage in activities that are hard to do in a depressed state of mind...’, and experts (5, 7 & 9) recommend initial directive facilitation in order to minimise frustration and despondency and help create a sense of comfort and safety. Expert (3) emphasises the need for realistic recommendations, given the availability of resources, time constraints and low energy levels, and adds that unrealistic recommendations could ‘...undermine the programme’s efforts to empower and build up resourcefulness and resilience’. Experts have different views regarding the usefulness of homework; some feel it would add to the parents’ already demanding schedules, as expert (4) explains: ‘I don’t think homework will be done by new parents, especially ones struggling with PND’, and expert (2) adds ‘...homework might be helpful but impractical’, while others (5, 7, 9) feel it could add value if it helps relieve stress and enhances the couple’s ability to cope.

By proving manageable input. Information overload and participation fatigue could burden group members. Experts (2, 3, 4, 6, 9 & 10) recommend condensing content and expert (9) states that including all the proposed content ‘...may overwhelm the participants’. After the second Delphi round, however, she emphasised the need for balance ‘...too little (content) may also leave participants feeling they obtained no usefulness from the group’.

By making concepts easy to understand and apply. An overwhelmed mind may find complex concepts cumbersome. Expert (10) explains ‘...(it) might be hard to process when

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already in a state of pre-occupation...'. Experts (2, 4 & 9) recommend making content easy to understand and practical, while expert (4) states 'If the focus is on what the parents can do so that they are able to cope...it is valuable, ...practical tools are essential'.

By being mindful of the impact of words. The importance of semantics was highlighted. Experts warned against language that could be regarded as insensitive or judgemental. Expert (4) states: 'PND mothers feel overly judged already and their inner dialogue is very critical'. Expert (3) recommends the use of 'tentative language' and experts (4 & 10) suggest words like 'dangers of untreated PND' be replaced with 'Risks' and 'fighting' be replaced with 'disagreeing and arguing'. Expert (10) cautioned against broad generalisations, while expert (2) warned against ambiguity: '...a statement like 'limit visitors' may be contradicting the previous idea of 'asking for help'.'

By balancing the bitter and the sweet. Expert (1) highlighted the importance of balancing the difficulties experienced with the pleasures of parenting: '...demystify the notion that parenting is easy, but with caution not to take away from the joy and happiness parenting can bring.' Experts (1, 2, 7, 8 & 10) caution against negativity, and expert (10) states '...be mindful not to incite guilt feelings by making negative instead of positive statements' while expert (8) advises '...to try and elicit motivational factors...', and expert (7) encourages instilling hope.

By balancing information and discussion. Experts identified the provision of a space for emotional expression as a way of adding value, and recommend a balance between programme content and discussion time. Expert (9) explains '... sufficient time has to be allocated to...discussions...so that couples can make it relevant to their contexts' and expert (3) adds, 'The content should inform and not substitute for discussion'. Most experts recommend a flexible implementation of programme content. Expert (4) comments '...you

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cannot offer everything. You will need to adjust what you focus on ... depending on the group'. Expert (5), however, warn against being overly flexible in compiling the manual as vital information could be omitted, and recommends 'make it clear that these are guidelines and the user is free to...adapt the manual'. Expert (3) makes an interesting comparison 'what is going to be key is the balance between structure and flexibility – this is an interesting, and pertinent continuum as it applies to parenting too, and particularly parents suffering from PND who may find themselves overwhelmed by being too flexible or else defensively being too structured...'

Specific content that experts indicated should be emphasised.

All participants found the manual content to be comprehensive. Three aspects were, however, considered to be of most importance. The module on medication was endorsed by nearly all experts. They recommended that the information be presented earlier in the programme. Secondly, experts emphasised the importance of providing practical tools. Most experts recommend the inclusion of relaxation exercises. Thirdly, experts highlighted the couple's relationship: expert (4) explains '...the couple's relationship can be the biggest resource in overcoming PND' and experts (5, 9 & 10) recommended the inclusion of more couple activities.

Experts' recommendations regarding the group process

Recommendations regarding setting the scene.

How you begin the group will lay the foundation of safety and trust and contribute to ownership and commitment. Experts (5, 6, 8, 9 & 10) emphasise the importance of 'beginnings', and recommend that the facilitator do a needs assessment, highlight the benefits of attending the programme and work towards cohesion among group members. Experts (5 &

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6) highlight the need for initial structure. Expert (5) explains ‘anxiety on the part of the participants is rife, hence the therapist may need to be directive...’, while expert (9) notes that collaborating with couples with regards to the group objectives ‘...creates a sense of ownership and commitment’ and creates realistic expectations regarding what the group can offer. Experts (4, 7, 9 & 10) stress the importance of cohesion, and that a lack thereof could hamper group participation.

Facilitators should help create links between the different modules. Participants (1, 4, 5, 8 & 10) raise topics of continuity and a sense of integration. They stress the importance of clear links between modules; expert (8) suggests ‘providing the clients a space to ask questions in the following session once they have had a chance to reflect on what they have learnt in this group’.

Recommendations regarding aspects affecting the group ambiance.

Don't throw them in the deep end! Experts highlighted the importance of creating a safe, participatory space. As mentioned, group ambiance is affected by the way groups begin. Expert (8) suggests ‘...an ice-breaker to reduce anxiety and tension ...’ and experts caution against the use of threatening content or activities, as expert (9) explains ‘Asking participants what is ‘hard for them to do’ at the beginning of the group process could be threatening as few parents want to admit to these bad feelings’. Due to the objectives and short-term nature of this group, experts recommend that intensity be minimised and emphasis fall on creating a safe supportive space. In this regard experts (5, 9 & 10) recommend the use of humour, fun, relaxing and non-threatening activities.

Be inclusive and accommodate differences. Similarly, to the comments about the content of the programme, experts recommended cultural and gender sensitivity when facilitating groups as this could impact on group members’ willingness to engage. Experts (2,

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7 & 8) emphasise cultural and gender differences in expressing emotions; expert (2) explains ‘... certain communities may be reluctant to share personal information’ and expert (8) states that safety in the group can be enhanced through open discussions about different perceptions and traditions, while expert (7) emphasises the importance of inclusion in order for all members to feel validated.

Provide containment and manage distress. Experts encouraged creating a containing space where group members would be able to share their experience without becoming overwhelmed by their emotions. Expert (3) states ‘The painful emotional experience needs space to be acknowledged ...’. Sensitive management of uncontained emotions is recommended. Expert (8) suggests involving a co-facilitator for this purpose, whilst expert (9) recommends that ‘...disclosures that cannot be contained within the parameters of the group...’ be avoided and individuals should be referred for therapy. Due to the nature of the group it is, however, inevitable that sensitive emotions will be evoked and expert (3) states that ‘The programme facilitator will need to be very mindful and skilful at managing the affective material and any group dynamics’. Experts (2, 4 & 8) highlighted the presence of the couple’s relationship dynamics within the group and recommend therapy outside the boundaries of the group for those couples where discord in the relationship impacts on their ability to benefit from the parenting group.

Pacing sessions. Experts (3&4) indicate that group members’ need to express themselves may slow the pace of sessions and expert (10) adds that emotional expression should not be rushed. Experts (5, 6 & 9) recommend that certain modules to be spread over 2 sessions, as expert (5) explains ‘There are a lot of important themes in this module. I would maybe suggest splitting the content into 2 modules’. Unfortunately, this will impact on the programme duration which was identified by most participants as problematic.

Let the group lead. Most participants recommend that after the initial directive facilitation to alleviate anxiety, the group process should be allowed to unfold spontaneously, by encouraging expression of feelings and sharing of personal experience. Expert (7) states ‘I would allow more time for group discussions. This is important for cohesion ... and therefore support’.

Strengths of the proposed programme as identified by experts

All experts identified strengths in the programme. These ranged from content being comprehensive, relevant and appropriate ‘good content and well thought out’ (6), valuable and informative ‘...they will have accurate information from this’ (4), to being fun, interesting, interactive, practical ‘...The couple exercise is also wonderful and practical and achievable’ (9), and easy to digest ‘...great examples to illustrate concepts’ (8). The inclusion of both parents in the programme was identified as a strength ‘What makes this programme unique is that the couple is attending and addressing the PND together’ (4), while expert (2) mentioned that there are few interventions available for families with PND and highlighted the benefits of offering this programme as a group intervention: ‘Group therapy can be effective, affordable and time efficient’.

Limitations and challenges of the proposed programme as identified by experts

Challenges were noted regarding relevance to different cultures and socio-economic levels, feasibility of the timeframe, sensitive use of language and excessive focus on the negative aspects of PND. Finally, experts noted that practical difficulties (i.e. childcare and time limitations) might have a negative impact on attendance.

Discussion

PND develops due to complex interrelated aetiological factors, therefore no single intervention will effectively treat all individuals diagnosed with PND (Dennis & Hodnett, 2007). In the light thereof, researchers have called for integrated holistic treatment programmes (Kane & Garber, 2004; Kathree & Petersen, 2012) to be developed for this vulnerable population.

With the aim of identifying those essential elements of an integrative parenting programme, a thorough literature analysis as well as semi-structured interviews with couples experiencing maternal PND were carried out (Ferreira & van Rensburg, in review). Thereafter, the gathered data was used to inform the compilation of a parenting programme. According to De Villiers et al. (2005), collective intelligence enriches individual judgement, and so the Delphi method was used to evaluate the programme, drawing from the experience of experts in the field of PND. The aim of the Delphi evaluation was not to reach generalizable consensus, but to seek expert knowledge to aid in the enhancement of the proposed programme (Brady, 2015). A diverse panel enhanced the credibility of expert input (Iqbal & Pison-Young, 2009). The experts commented on the structure, content, process, strengths, limitations and challenges pertaining to the proposed programme.

With regards to structuring a programme, Yalom and Leszcz (2005) state that the success of a group intervention is determined by thorough performance of pre-therapy tasks. Experts in this study highlighted the importance of identifying the intended target population as well as determining the feasibility of the programme. An important pre-therapy task involves establishing inclusion criteria. Experts in this study recommended excluding high-risk couples from the group and referring them for treatment (medication, individual therapy, couples therapy). It is essential to determine initially whether couples are able to participate in the key tasks of the group, especially in a short, time-limited programme (Yalom &

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Lesczc, 2005). Experts identified the programme duration and module length as factors that could affect feasibility and recommended that the programme duration be shortened. Some researchers, however, found good attendance in medium-term groups (8-12 weeks) (Morgan, Matthey, Barnett, & Richardson, 1997) and De Camps Meschino, Phillip, Israel and Vigod (2015) even recommended prolonging their 12 week programme. Milgrom et al. (2006b) however report that parents dropped out of their 12 week programme prematurely due to experiencing symptom relief early on in the programme. Studies found that group attendance is affected by perceived benefits and support with regards to childcare (De Camps Meschino et al., 2015; Morgan, et al., 1997; Shapiro & Gottman, 2005). In line with recommendations by Milgrom et al. (2006b), experts in the current study suggest employing childminders.

With regards to the programme content, experts encouraged the accommodation of diverse viewpoints and beliefs regarding childrearing practices. Dennis and Chung-Lee (2006) emphasise the importance of knowledge concerning different cultural perspectives and available community resources as this will affect the appropriateness of recommendations to parents. Experts suggested a flexible approach in presentation of the manual content depending on the needs of the group, and emphasise that an intervention should add value and not add to the demands parents are already battling to manage; this is corroborated by Milgrom et al (2006b). Experts further emphasised the sensitive use of language because self-criticism and negative thoughts are prominent features of PND (Stein, Lehtonen, Harvey, Nicol-Harper, & Craske, 2009), and presenting a balance between the rewards and challenges that parenting brings. Most experts recommend a less didactic focus and allowing more time for discussion. Conversely researchers in the field (Letourneau et al., 2011; Lyons-Ruth, Wolfe, & Lyubchik, 2000; Vigod, Wilson, & Howard, 2016) found information and knowledge to be essential factors in treating families who suffer from PND. Shapiro, Nahm, Gottman and Content (2011) however cautioned against a programme that focusses too much

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on didactics as it may be very difficult for sleep deprived parents to attend to. Milgrom et al. (2006b) warns against the use of manuals in a mechanical way without considering the unique circumstances of each individual. This suggests a balance between workshop material and exploration of the lived experience as suggested by the panel of experts.

With regards to the group process, experts note that the level of cohesion and sense of safety will determine participant's willingness to engage. Groups with stronger cohesion have higher rates of attendance, participation and peer support (Yalom & Leszcz 2005). Experts stress the importance of a non-threatening, inclusive space where participation by all members is encouraged and acknowledged. The emotional nature of a group focussed on PND was highlighted. Experts recommend a co-facilitator to assist with emotional containment and also state that the need to express emotions could slow the group process down, but it is a shared belief among experts that the facilitator should follow the group's lead and not prescribe manualised content as individuals may benefit greatly from emotional expression and perceived social support. Ultimately, the facilitator needs to offer something of benefit to the group. Milgrom et al., (2006b) states that the facilitator needs to apply clinical judgement coupled with a formalised approach in order to best meet the needs of participants.

The greatest benefit in using a Delphi method was the illumination of limitations. Experts highlighted aspects relating to the structure of the programme and content, as well as group process that could impact on the success of the intervention. The most difficult aspect of using the Delphi method with a group of experts from different disciplines pertained to the different theoretical paradigms which guides therapeutic focus. Even though the proposed programme is intended to be an integrative programme drawing from different theories, the researchers found it challenging to incorporate varied recommendations due to the

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comprehensive nature of the compiled programme as well as the limited time parents will be able to devote to it.

Despite the limitations mentioned, experts found the programme content to be comprehensive and noted that a programme of this nature would benefit couples who experience PND. The fact that both partners are included in the intervention and that it is offered in group format was identified as strengths.

Conclusion

In conclusion the researchers found the Delphi method to be a very useful and relatively quick way of gathering valuable information from professionals with extensive experience. This allows the researchers to construct the proposed programme around the most essential elements as highlighted by experts in the field. The data gathered from the Delphi panel will be used to review and refine the proposed parenting programme, whereupon the final programme will be published.

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Conflict of interest

The authors declare that they have no conflict of interest.

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Acknowledgments of people, grants, funds, etc. should be placed in a separate section on the title page. The names of funding organizations should be written in full.

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- Negotiation research spans many disciplines (Thompson 1990).
- This result was later contradicted by Becker and Seligman (1996).
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Slifka, M. K., & Whitton, J. L. (2000) Clinical implications of dysregulated cytokine production. *Journal of Molecular Medicine*, doi:10.1007/s001090000086
- Book
Calfée, R. C., & Valencia, R. R. (1991). *APA guide to preparing manuscripts for journal publication*. Washington, DC: American Psychological Association.
- Book chapter
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- Online document

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Abou-Allaban, Y., Dell, M. L., Greenberg, W., Lomax, J., Peteet, J., Torres, M., & Cowell, V. (2006). Religious/spiritual commitments and psychiatric practice. Resource document. American Psychiatric Association. http://www.psych.org/edu/other_res/lib_archives/archives/200604.pdf. Accessed 25 June 2007.

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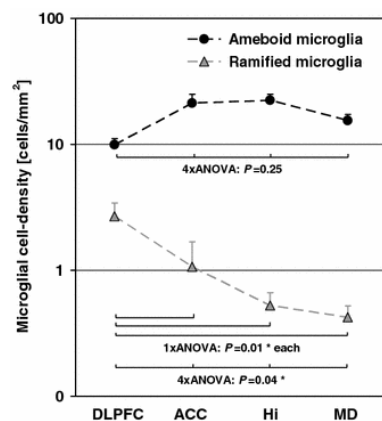
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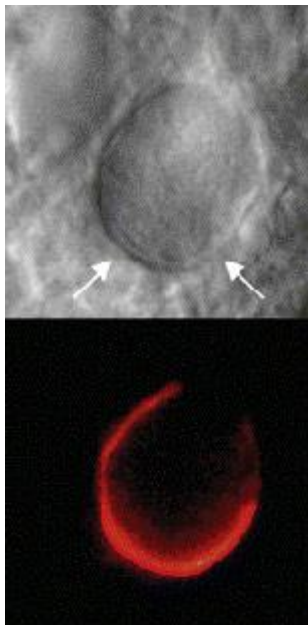
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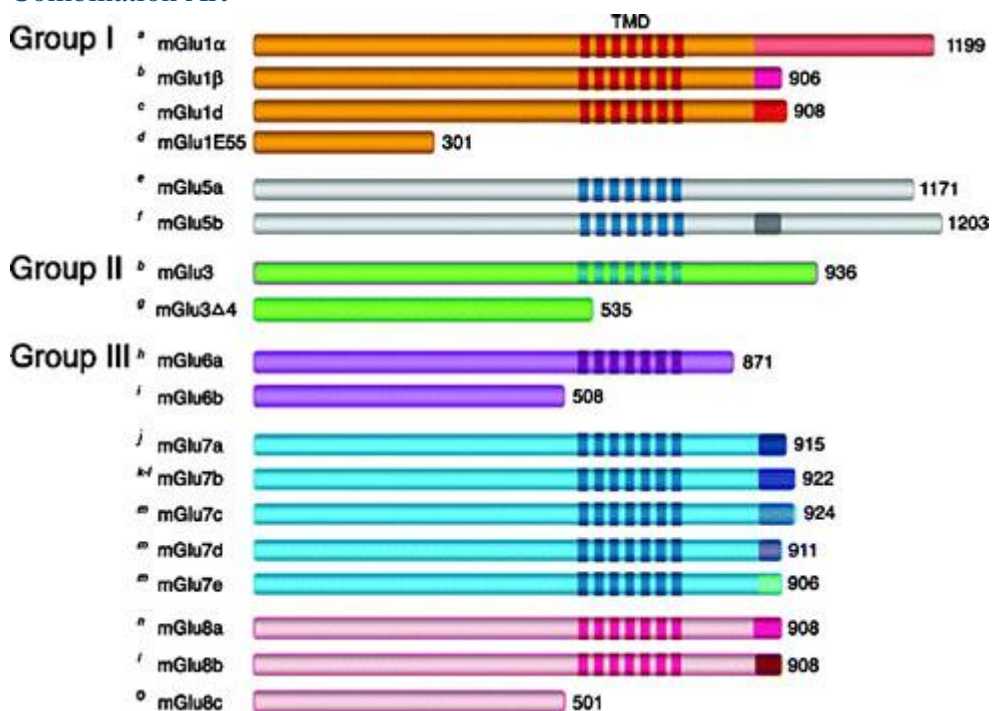
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***Building Blocks: A Parenting Programme for Couples Experiencing
Maternal Postnatal Depression***

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Ms. S. Baker, Dr N. Dugmore, Ms. H. Hardudh-Dass, Ms. C. Jacobs-Richards, Ms. B. Lane, Dr L. Lumu, Dr C. Marsay, Dr A Miric, Dr A. Silva & Ms. A.vd Heever.

Abstract

Previous research has advocated for the inclusion of both parents in postnatal depression interventions due to the central role of relationship factors in the development and maintenance of postnatal depression. This paper describes the *Building Blocks* programme, a parenting programme that was developed for couples who experience maternal postnatal depression. The structure and content of the programme have been informed by a thorough analysis of the existing literature, interviews with couples who experience maternal postnatal depression and an evaluation of the programme by experts in the field of postnatal depression as guided by the Delphi method. The programme spans over seven weeks, covers six modules and aims to address the contributing and maintaining factors of PND and assist couples in creating a healthy, nurturing environment for their families. It is an integrative, holistic programme in that it integrates elements from different evidence-based paradigms that have proved effective in the treatment of PND, including psycho-education, cognitive behaviour therapy, behavioural marital therapy and Theraplay®.

Keywords Postnatal depression • Couples • Parenting • Programme

Introduction

The birth of a new baby is normally associated with a joyous and exciting period (Mulcahy et al. 2010). However, a significant proportion of couples experience a deterioration in relationship satisfaction within the first few years of parenthood (Condon et al. 2004; Schulz et al. 2006), most probably due to a disillusioning discrepancy between what the couple anticipated and the reality of parenting (Hunt 2006; Yim et al. 2015). The transition from being a couple to becoming parents encompasses a stressful period, during which families experience numerous biological, emotional and interpersonal changes and need to adapt to new roles and responsibilities (Roehrich 2007). These constant and rapid changes could challenge the couple's relationship and lead to relationship discord. An unstable relationship with an unsupportive partner, combined with the difficulty of managing increasing demands, could put individuals at risk for mental health difficulties in the postnatal period (Page 2008; Seymour et al. 2014; Yim et al. 2015).

One of the more serious difficulties that could develop during this period is postnatal depression (PND), a common mental healthcare problem with a worldwide prevalence estimated to be between thirteen and nineteen percent (O'Hara and McCabe 2013). PND has a severe impact on the individual as well as the family system (Dennis et al. 2004; Grigoriadis and Ravitz 2007; Yim et al. 2015). Mothers are especially vulnerable during the first six months post-birth, but recent research indicates that symptoms of depression can develop up to twelve months postnatal (O'Hara and McCabe 2013). The symptom profile of PND is similar to that of Major Depressive Disorder, and symptoms have a profound impact on the mother's functioning and wellbeing in all spheres of life (Vigod et al. 2016). The main difference is the added stressor of being responsible for a very needy infant while coping resources are depleted (O'Hara and McCabe 2013). The most obvious symptoms that differ

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from those of major depressive disorder (MDD) are an overwhelming fear for the infant's wellbeing, fear of being alone with the infant and intrusive thoughts of harming the baby (Ray 2014).

Ongoing research have made attempts to identify causative factors, and have found that there are numerous and varying unique, interacting, internal and external factors contributing to the development of PND (Ayers et al. 2016; Craig et al. 2005; Dennis and Hodnett 2007; Wiklund et al. 2010). Rowe and Fisher (2010) have identified four well-researched risk factors, namely: personal psychiatric history, unexpected adverse life events, relationship difficulties with an intimate partner, and poor social support. Of these four, two factors, namely relationship difficulty and social support, are modifiable and can successfully be addressed by means of an intervention. Regardless, few programmes prepare couples for the adjustment post birth, for the effect parenting will have on their relationship (Pilkington et al. 2016; Schulz et al. 2006; Shapiro and Gottman 2005), or for the possibility of having to deal with a mental illness (Roehrich 2007).

According to the Interpersonal theory, relationships are central to the development, maintenance and recurrence of depression (Grigoriadis and Ravitz 2007; Mulcahy et al. 2010), and relationship instability and dissatisfaction have been identified as some of the strongest predictors of PND (Dalfen 2009; Dennis and Ross 2006; Grigoriadis and Ravitz 2007; Milgrom et al. 2006a; Mulcahy et al. 2010; Venis and McCloskey 2007). Good partner support, emotional closeness and relationship satisfaction have all been identified as protective factors against the development of anxiety and depression (Pilkington et al. 2016; Ramchandani et al. 2009; Yim et al. 2015). According to Shapiro and Gottman (2005), it is surprising that, given the importance of this challenging transitional phase in a couple's

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relationship, so little research on preventative intervention and conflict management has been done.

Various research studies have explored the value of psychotherapy in the treatment of maternal PND. Cognitive Behavioural Therapy, Interpersonal therapy (Grigoriadis and Ravitz 2007; Mulcahy et al. 2010), baby massage (Zauderer 2008), parenting groups (Milgrom et al. 2011) and group interventions (Kurzweil 2008) have achieved positive outcomes. Most studies, however, have focussed on maternal mood (Wang and Chen 2006), whilst the effective treatment of mood has little to no effect on alleviating parenting stress (Milgrom et al. 2006a). A review by Clatworthy (2012) indicates that successful PND interventions include a major interpersonal component, but these studies have been criticised for concentrating solely on the pregnant mother. Furthermore, researchers recommend interventions focusing on parenting support and psycho-education (Letourneau et al. 2011; Lyons-Ruth et al. 2000).

There are several programmes that aim to support parents who suffer from PND, including the *EPIC* programme (Buultjens et al. 2008) and the *Mellow Babies* programme (Puckering et al. 2010), which focus only on the mother and infant, as well as *The Getting Ahead of Postnatal Depression* programme (Milgrom et al. 2006b) which has the option to include partner sessions. Researchers however stress the importance of including both partners in a therapeutic process in order to mobilise more support for the struggling individual and assist in enhancing parenting self-efficacy (Barnes 2006; Iles et al. 2011), while at the same time offering support and guidance to the partner, as this could have benefits for the family system as a whole (Kane and Garber 2004; Reck et al. 2011).

The *Bringing Baby Home* programme of Shapiro and Gottman (2005) is a sixteen-hour, weekend psycho-communicative-educational workshop that includes both partners

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throughout the intervention. It is aimed at expectant parents or parents who have recently had a baby. The programme has three treatment goals: strengthening the couple's relationship; facilitating equal involvement in childrearing; and psycho-education regarding parenting and childhood development (Shapiro and Gottman 2005). The programme was not designed with the primary aim of alleviating the symptoms of PND, yet some mothers who suffer from depression did experience symptomatic relief. Facilitators nonetheless found that many couples could not relate to content on PND (Buzzard-Speights 2013), possibly due to the target population not suffering from depression (Gottman et al. 2004). Critique regarding the programme includes the length of sessions and the volume of workshop preparation (Buzzard-Speights 2013). Furthermore, negative cognitions, which is a prominent symptom in parents who suffer from PND (Dalfen 2009; Leigh and Milgrom 2008; Seymour et al. 2014; Sword et al. 2012), as well as the individual needs of parents, factors which are essential in building resilience to cope with parenting demands (Puryear 2007), and the strengthening of the individual's or couple's support structure (Cowan et al. 2010), are not addressed adequately.

Previous studies have called for the incorporation of both parents in an integrative holistic treatment programme (Petch 2006, Kane and Garber 2004; Kathree and Petersen 2012; Milgrom et al. 2006a; Mulcahy et al. 2010; Paulson and Bazemore 2010), that aims to strengthen the couple's relationship, and to address adult mental health and parenting skills, and could be tailored to the specific needs of each individual (Hunt 2006; Solomonov and Barber 2016). An intervention with a bio-psycho-social focus, that considers the needs of the family as a whole, could lower risks involved in the negative consequences of a mental illness on the family system (Kane and Garber 2004; Reck et al. 2011). This study aims to address the mentioned need. As far as the researchers are aware, no other South African study has developed a postnatal programme specifically for couples where there is focus on all the

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following aspects: strengthening the support system and combatting isolation; psycho-education with regards to PND; strengthening individual coping resources; improving the couple's interactional style and working towards a healthier, supportive relationship between partners; increasing the parents' sense of self-efficacy; and facilitating moments of joyful interaction as a family. The purpose of this paper is to describe the *Building Blocks* programme, an integrative parenting programme for couples who experience maternal PND.

Method

Design

Thomas and Rothman (2013) have brought together some of the important common features of Developmental Research, Social Research and Development, and related approaches to provide researchers with an integrated model of Design and Development (D&D), serving as a guide for the generation of interventions (Thomas and Rothman 2013). The D&D model consists of six phases: problem analysis and project planning; information gathering and synthesis; intervention design; early development; evaluation and advanced refinement; and the dissemination of the programme.

Phases in the design and development of a parenting programme for couples who experience maternal postnatal depression.

During the initial stages of this research project a thorough analysis of existing literature was done pertaining to the nature of maternal postnatal depression. This set the theoretical foundation for the programme. Thereafter, couples who were experiencing maternal PND were interviewed about their parenting and PND experience (Ferreira and van Rensburg *a in review*), and key problems experienced by couples were identified and

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analysed. A clear understanding of what other researchers have done in the same field was obtained through the perusal of existing literature available on EBSCO HOST. Databases included: Academic Search Complete, CINAHL plus with full text, Global Health, Health Source: Nursing/Academic Edition, Humanities International Complete, Psychology and Behavioral Sciences collection and PsycInfo. Furthermore, an internet search was done using Google Scholar, and relevant secondary sources mentioned in journals were reviewed. Data obtained through the interviews helped to broaden the knowledge base by testing the information gathered in the literature against the lived experience of couples (Ferreira and van Rensburg *a in review*). The feasibility of the D&D project was determined, upon which the researchers developed a preliminary postnatal parenting programme for couples who experience maternal PND with the following objectives in mind:

- to reduce isolation and offer support to parents who experience maternal PND and are struggling to cope during this transition period;
- to encourage and strengthen support through increasing knowledge, by providing psycho-education regarding PND and the range of support resources that are available;
- to address cognitions that might contribute to the development and maintenance of depressive symptoms;
- to improve individual self-care;
- to strengthen the couple's relationship;
- to provide parents with practical skills to improve their coping ability and aid in the enhancement of self-efficacy and self-esteem; and
- to facilitate the mobilisation of resources to aid in a healthy balance between the fulfilment of the needs of all family members.

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In the next phase of the research the proposed programme was submitted to a panel of experts, working in the field of PND, for evaluation regarding its structure and content (Ferreira and van Rensburg *b* in review). Through the use of triangulation (literature analysis, interviews with couples who experience maternal PND and an evaluation by a panel of experts), scientific rigour was enhanced, a comprehensive understanding of a multifaceted phenomenon was achieved (Jones and Bugge 2006) and four groups of essential needs for a programme of this nature were identified: 1) Support/debriefing; 2) Knowledge (psycho-education); 3) Cognitive restructuring; and 4) Practical skills acquisition. The final phase of D&D entails the compilation and distribution of the finalised intervention programme. The focus of this article is therefore the publication of the final programme outline and content in scientific literature.

Building Blocks: A Postnatal Parenting Programme

Theoretical Principles for the Compilation of the Programme – An Integrative Perspective

Lazarus (2005) emphasises that no one theoretical school of thought can provide solutions to the vast range of problems individuals experience. This echoes the viewpoint of Dennis and Hodnett (2007) that no single intervention can address all the complex factors surrounding PND. Therefore, a technical eclectic approach (Corey 2005) was chosen in order to achieve the set objectives. This was done by incorporating various tools from different theoretical schools that have proved useful in previous studies or have been recommended by researchers and are likely to be effective in addressing the presenting problem of diverse individuals (Gold 2002; Lazarus 2005).

The objectives of the integrative parenting programme**Objective 1: Strengthening the support structure and combatting isolation.**

Group therapy has been extensively researched and has shown positive outcomes in the treatment of depression (Yalom and Leszcz 2005). Offering the intervention in a group format has the benefit of reducing social isolation, an important aspect that maintains depression (De Camps Meschino et al. 2016). It could furthermore enhance the mother's ability to cope (Milgrom et al. 2006b) and has proved effective in treating PND (Craig et al. 2005; Goodman and Santangelo 2011).

Objective 2: Providing information on PND.

Cohen et al. (2014) highlight the importance of psycho-education as a way of improving insight regarding PND, enhancing partner support and addressing relational difficulties. Psycho-education has emerged as one of the most effective evidence-based intervention practices (Lukens and McFarlane 2004) and is effective in treating PND (Australian Psychological Society 2010).

Objective 3: Addressing cognitions that could contribute to PND.

Negative thought patterns and lack of interest in activities are prominent features in individuals suffering from PND (Milgrom et al. 2006b). Therefore, clinical guidelines recommend the use of Cognitive Behavioural Therapy (CBT) in treatment (Meki 2014). According to the Australian Psychological Society (2010), CBT has the highest sufficient research evidence in treating adult depression successfully and has been found to be as effective as anti-depressants, speeds up recovery in conjunction with medication and has good long-term positive outcomes (Cuijpers 2013). Negative cognitions are, however, not the only contributing factor in the development of PND and depression is not the most prominent

symptom that is experienced in PND (Beck and Indman 2005). Consequently, CBT was not considered in this programme as a stand-alone treatment, but as complementary to other evidence based tools.

Objective 4: Improving self-care.

Mothers suffering from PND tend to neglect their own needs, and this leads to the depletion of coping resources (Ferreira and van Rensburg *a in review*). The partner of an individual who suffers from PND is most likely to experience the negative impact of the depression first-hand and is also at a high risk of developing depression (Lee and Chung 2007; Pinheiro et al. 2006). Therefore it is very important to address the self-care of both partners. Self-reflection is needed in order to gain self-knowledge and emotional awareness (Hixon and Swann 1993; Philippi and Koenigs 2014). This process is essential in being able to identify personal needs, achieve positive therapy outcomes and for psychological growth (Elliot and Coker 2008; Philippi and Koenigs 2014). The self-reflection used in this programme is guided by questions that aim to empower individuals to take control over that which they can control.

Objective 5: Strengthening the couple's relationship.

Relationship problems and lack of partner support can contribute to the development of PND (Kathree and Petersen 2012; Wiklund et al. 2010). Depression can lead to loss of interest in daily activities or friendships, withdrawal and isolation, and difficulties with regards to emotional and physical intimacy. This could have a negative effect on couples' relationships (Iles et al. 2011). Partners may find it difficult to give or receive support to each other or to create a nurturing environment for their baby (Glavin 2012). Depression can effectively be treated by addressing the intimate partner relationship (Beevers 2011; Cohen et al. 2010) and therefore elements of Behavioral Marital Therapy (BMT) were used in the

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programme. BMT is a brief therapeutic intervention for couples where one partner is depressed and the couple experiences marital discord, problem areas in the couple's relationship are explored and addressed, whilst focussing on increasing positive interactions (Beevers 2011). BMT is the best documented, most researched approach of treating depression in the couples intervention process (Gupta et al. 2003), and has achieved high level evidence-based outcomes (Beevers 2011; Chambless and Ollendick 2001). BMT has also shown success in concurrently treating those individual problems (i.e. depression) which are the cause of, or maintained by, relationship problems, while addressing relationship difficulties (Birchler 2002). Once again, as suggested by Dennis and Hodnett (2007), focussing on a single aspect of PND, namely relationship difficulties or depression, would not effectively treat the complex presentation of PND. Therefore, an integrative approach was employed.

Objective 6: Providing practical skills to improve coping ability while keeping the infant's needs in mind.

The difficulties experienced by mothers who suffer from PND in providing attentive, warm parenting (Emanuel 2006; Pilyoung and Swain 2007; Venis and McCloskey 2007) as well as the negative impact of PND on the infant's development (Davé et al. 2010; Dørheim et al. 2009; Ramchandani et al. 2008; Ramchandani et al. 2011) are well documented. Furthermore, literature, as well as data gathered from interviews with couples who experience maternal PND (Ferreira and van Rensburg *a in review*), highlighted the prominence of feelings of incompetence among mothers who experience PND. The researchers included elements from Theraplay® (Jernberg and Booth 2001), an attachment-based parent-infant intervention, to empower parents with practical tools to assist in facilitating a healthy parent-infant bond. Theraplay® has good empirical support in its theoretical foundation of

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attachment theory and there is a growing base of research to support its efficacy (Munns 2011). Several studies have demonstrated positive parent-infant treatment outcomes over a short period of time (Rumley 2004).

Structure of the programme

The *Building Blocks* programme was developed for couples who experience maternal PND. Its design is based on a thorough literature analysis and information gathered from case studies by means of semi-structured interviews (Ferreira and van Rensburg *a* in review) and expert input and evaluation (Ferreira and van Rensburg *b* in review). Due to the nature of the research sample, the content of the manual applies to heterosexual, middleclass parents who are married or co-habiting and would have to be adjusted according to the needs of different populations (i.e. single parents, gay parents, or parents with very limited resources). Due to the complex nature of PND as well as the material included in the programme, facilitators of the Building Blocks programme need to be registered with a regulatory board (i.e. HPCSA) and have a Masters level of training in psychotherapy, or be supervised by a registered psychologist. Furthermore, the facilitator would need to have adequate knowledge regarding PND, Behavioural Marital Therapy, Cognitive Behaviour Therapy as well as the attachment based therapy technique Theraplay.

The intervention is intended to be offered over seven weeks, once a week for approximately two hours and includes six Building Blocks, each with a unique focus, which are all interrelated in the ultimate goal of assisting parents to cope better during this challenging transition period. It takes on the form of a ‘closed’ group and accommodates five couples at a time. Facilitators are encouraged to do a needs analysis regarding the need for childcare or childcare facilities as it would benefit the parents not to bring their infants to the sessions, but this could be impractical and could affect attendance negatively.

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The programme is designed to be both didactic and interactive, with time for self-reflection, couple and group discussions, and it includes multimedia (should technology be available) to illustrate concepts, and humorous video clips in order to create a comfortable space and lighten the serious nature of sessions. Participants receive a manual that includes all material covered in sessions as well as homework activities, and the manual provides space for personal reflection and notes.

The *Building Blocks* programme aims at creating a supportive space where couples can share their experiences freely whilst at the same time equipping parents with knowledge and skills in order to feel more confident in dealing with their daily demands and strengthening their support system. There is a strong focus on psycho-education in this programme and the facilitator takes on the role of educator, but is also instrumental in creating a safe space for sharing and encouraging couple and peer support. Experts participating in the evaluation of the preliminary programme (Ferreira and van Rensburg *in review*) have emphasised the importance of creating a containing space where participants could share their emotional experience, and they have advised against rigid didactic facilitation, but rather for the manual to serve as a guide that informs discussion. It is also recommended that most of the practical or coping ideas be generated within the group as each individual has unique circumstances and resources and couples will therefore not be able to follow ‘instructions’ or plans thought out by the facilitator. There are, in addition, ample recommendations available in the manual that could be used to help generate discussions among members.

All participants should be screened for risk prior to joining the group intervention as the choice of treatment options depends on the severity of the depression (Vigod et al. 2016). An individual presenting with severe symptoms might not benefit from a group intervention

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prior to finding some symptomatic relief. Should clients present with severe symptoms of PND and pose a risk to themselves or others, they should be referred to a healthcare practitioner immediately.

Programme Outline

The name of the programme *Building Blocks* refers to the focus areas of the modules that aim to assist couples in building a healthy, nurturing environment for their families.

Session 1: Information session.

The aim of the first session is to do orientation, offer information about the programme and provide members with the opportunity to meet other couples who will join the group process.

As anxiety would likely be rife in a first session (Milgrom et al. 2006b), the facilitator provides structure and guides the discussion points in this session. The programme starts with introductions, general orientation and the setting of group norms and values. In the forming stages of a group, members could require assistance in getting to know each other and to feel comfortable sharing their experience with one another (McLaughlin and Peyser 2011). The facilitator could introduce an ice-breaker, as this is an effective tool in helping members to ease into the process and get to know each other (Eitington 2011). Part of the discussion centres around members' expectations of the programme and aligning that with the objectives of the programme. Thereafter, the facilitator could make use of a slide show or pictures from magazines to introduce the topic of how pregnancy and parenting are portrayed in the media. The group is invited to participate in a group discussion about the myths, the expectations and realities of parenting. The aim of this discussion is to allow group members the opportunity to share their experience regarding dreams versus reality, and also to discover that they are not alone in their experience of this challenging transition.

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All of the sessions that follow start with a short review of the previous session, and this allows time for questions regarding previous modules; all sessions end with time for questions and answers.

Session 2: The parenting journey and postnatal depression.

Session two covers two Building Blocks. Building Block one explores each couple's parenting journey, and how life has changed since becoming parents. Challenges and difficulties experienced by parents are acknowledged. Furthermore, the mass of information that bombards parents about the 'right' way to parent, and the challenges regarding having more than one child are shared. Seymour et al. (2014), state that parents need the opportunity to 'normalise' their experience. It helps when parents know they are not alone; this strengthens cohesion and sets the stage for participants' willingness to share their experiences in the sessions that follow (Yalom and Leszcz 2005). At the same time, it also provides couples with the opportunity to debrief regarding their pregnancy, birth or childcare experience. Experts on the panel that evaluated the preliminary programme (Ferreira and van Rensburg *b in review*) cautioned against excessive focus on the negative and challenging aspects of parenting, therefore, the facilitator needs to balance group discussions by also looking at positive elements. Humour is a good tool in therapy to reduce tension, and build trust, and can aid in strengthening group cohesion (Dziegielewski et al. 2003); a humorous video clip could be included to break the serious nature of the programme content. This module ends by highlighting the fact that, even though each couple participating in the programme have unique circumstances, they are all affected by PND. The purpose of the emphasis is to enhance the awareness of a shared experience in order to strengthen cohesion and encourage openness in the group (Leszcz and Kobos 2008), and links the group discussion to the psycho-education module that follows.

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Building block two involves providing couples with information regarding the nature of PND, and the vulnerability factors that contribute to its development as well as treatment options that are available.

Information and knowledge are very important factors in treating families who suffer from PND (Letourneau et al. 2011; Lyons-Ruth et al. 2000; Vigod et al. 2016). This part of the programme adds value in that it confirms the existence of a diagnosable illness, as many couples may not understand what is happening to them (Dalfen 2009; Matthey et al. 2016; Misri 2006); it explains to couples why they may be experiencing difficulties, and it could facilitate enhanced support to both partners (Matthey et al. 2016; Roehrich 2007). The content includes information on the nature of PND, risk and maintaining factors, and paternal PND, as well as information regarding the impact of PND on the individual, couple and family system. Because parents are already suffering emotionally, the impact of PND is not focussed on at length as experts on the panel that evaluated the programme (Ferreira and van Rensburg *b in review*) indicated this might lead to feelings of persecution and judgement. Enough information is, however, included in the facilitator's manual as a knowledge base for facilitators, whereas the information in the participants' manual focusses on the importance of reaching out for help. This session ends with information regarding treatment options available to individuals and families who experience PND. A resource list is included at the back of the manual and facilitators are encouraged to add information pertaining to local resources, depending on the community they serve.

Session 3: The connection between thoughts, emotions and behaviour.

Building block three highlights how cognitions contribute to emotional experiences, and aims to encourage a healthier outlook on life. This is viewed as a very important block in

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the foundation of mental health and healthy interpersonal relationships (Dalfen 2009; Milgrom et al. 2006b; Wilkinson and Mulcahy 2010).

Many mothers experience emotional difficulties that emanate from the way they perceive their parenting experience, support and abilities (Ferreira and van Rensburg *a in review*). Maladaptive and unhealthy thinking styles were identified during the interviews as factors that maintain PND, and this is supported by research findings (Beck 1995; Corey 2005; Digiuseppe et al. 2014). This Block focusses on the interconnectedness of thoughts, emotions and behaviour and aims to facilitate the adoption of a healthier way of thinking about experiences as this could enhance more adaptive coping skills (Ray 2014). Building Block three is mostly a didactic module: participants learn through theory as well as practical examples how their thoughts could precipitate and perpetuate depression and anxiety and how their behaviour could maintain a depressed or anxious mood. Individuals are likely to feel different and act differently if they are able to change the way they think about a given situation or experience. Similarly changes in behaviour can lead to altered thoughts about experiences (Beck 1995; Corey 2005; Digiuseppe et al. 2014). The Building Block covers information regarding the influences of the family of origin (Gottman and Gottman 2007; Milgrom et al. 2006b) and society on belief systems (Barnes 2006) as well as a practical element in providing participants with tools to help them manage their emotions, particularly anxiety, more effectively. Two homework activities are included in preparation for the next module: couples are requested to engage in a brainstorming activity with the aim of increasing support resources, and they are also asked to complete a self-reflection activity regarding self-care.

As every individual in a system is interconnected and has an impact on each other, an intervention would be most effective if it were to address the needs of the whole system

(Bitter and Corey 2005). Building Blocks four, five and six address the needs of each part of the family system, namely: Parents' individual needs, couples' needs and the infants' needs.

Session 4: Individual needs of the parents.

The postnatal period is a stressful adjustment (O'Hara and McCabe 2013), during which many parents feel disillusioned by new roles and responsibilities and often do not have time to attend to their own needs (Misri 2006). This could contribute to challenges in coping with constant demands (Hunt 2006; Yim et al. 2015). Building Block four centres around the needs of the parents as individuals. Good self-care was identified as an essential requirement in order to be able to provide for the needs of others (Dalfen 2009; Venis and McCloskey 2007). The aim of this module is to strengthen the coping resources of the individual to enable parents to deal with daily demands whilst finding ways to enjoy this phase of life.

The session starts with self-reflection regarding the individual's experience of her/himself now that she/he has become a parent. This is aimed at enhancing self-awareness in order to be able to identify personal needs, a very important aspect in the treatment of PND (Elliot and Coker 2008; Philippi and Koenigs 2014), as good self-care is needed to cope with parenting demands (Dalfen 2009; Venis and McCloskey 2007). Thereafter, each individual draws up a needs analysis for his/her personal needs, and identify obstacles he/she encounters in trying to meet these needs. Many ideas of ways to meet physical, psychological, spiritual and social needs are included in the manual, but this should be seen as a guide only as it would be more meaningful and relevant for couples to generate ideas among themselves (Ferreira and van Rensburg *b* in review). The module includes a homework activity for couples that entails a discussion regarding the influences of parenting on their relationship in preparation for the next module.

Session 5: Needs of couples.

The fifth block focus on strengthening the couple's relationship. The health of the relationship with an intimate partner was identified as a contributing and maintaining factor in the experience of emotional difficulties in both partners (Dalfen 2009; Dennis and Ross 2006; Grigoriadis and Ravitz 2007; Milgrom et al. 2006a; Mulcahy et al. 2010; Roberts et al. 2006; Venis and McCloskey 2007; Wee et al. 2011), but can also be a protective factor (Yim et al., 2015).

New, uncertain role adjustments and expectations could bring about stress and conflict in the couple's relationship (Ray 2014); many couples experience a decline in relationship satisfaction and report a lack of practical and emotional support (Condon et al. 2004; Schulz et al. 2006). Furthermore, PND could result in an emotional barrier between partners (Roehrich 2007). A mother who suffers from PND could struggle to cope with childcare and household responsibilities on her own, requiring the partner to take on more responsibility (Roehrich 2007), whereas the partner might experience stress to maintain the family's financial wellbeing, and this could lead to tension in their relationship (Barnes 2006). The mother could also feel resentful towards her partner for being able to resume a "normal" routine, whereas her needs, goals or other roles are set aside (Roehrich 2007). Being in an unhappy, unsupportive relationship can contribute to mental health difficulties (Seymour et al. 2014) but simultaneously, mental health difficulties could impact negatively on the couple's relationship (Hunt 2006). The session starts with a group discussion regarding possible reasons for relationship difficulties after starting a family. The rest of the module focusses on empowering both partners to take responsibility for the happiness and health of their relationship. Couples practise communication and conflict management skills through roleplays, by engaging in a group discussion on intimacy, and participating in a couples' needs analysis. Furthermore, the group engages in a brainstorming activity of finding ways to

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reconnect as a couple. This is followed by couples committing to some of the identified activities with the aim of facilitating a deeper connection between partners. The session ends with an activity that requires individuals to identify positive qualities about their significant other and to express appreciation for those qualities.

Two homework activities are included: couples are requested to read two pages in their manual regarding PND and how to support their loved-one, but also on how to cope and take care of themselves; as well as a letter-writing exercise to help individuals express to their partners what they need in order to cope better during this stressful time.

Session 6: Needs of the infant.

Building Block six serves two functions, empowering parents by providing couples with basic, easy tasks in creating an environment conducive to healthy parent-infant attachment (Jernberg and Booth 2001) and secondly to ensure that the needs of the infant are met, as often PND interferes with sensitive, attentive parenting (Emanuel 2006; Pilyoung and Swain 2007; Venis and McCloskey 2007).

PND affects the parent's ability to attend to the infant's needs effectively (Ray 2014), while parent-infant interaction patterns could precipitate and perpetuate mental health difficulties, which could diminish the positive nature of the parenting experience and have negative long-term effects for the infant (De Camps Meschino et al. 2016; Goodman et al. 2013; Seymour et al. 2014). Furthermore, many mothers struggle with confidence regarding their parenting abilities (Gaillard et al. 2014). PND could be exacerbated by a low self-esteem and feelings of incompetence (Beck 2001; Dennis and Hodnett 2007; Lee and Chung 2007; Leigh and Milgrom 2008; Liu et al. 2011; Milgrom et al. 2006a; Nonacs 2006; Venis and McCloskey 2007) and providing the parents with some basic, practical tools could serve to empower them. The focus of the discussion falls on "Good-enough-parenting" and the

concepts formulated by Jernberg and Booth (2001) of structuring, engagement, challenging and nurturing are introduced as a means of fostering healthy attachment.

Session 7: Practical parent-infant session and termination of the programme

The final session entails practical parent-infant activities applying the principles of Theraplay®: structuring, engaging, challenging and nurturing (Jernberg and Booth 2001) that were addressed in session six (Building Block six: Needs of the infant) and also the termination of the programme. Due to the amount of information covered in previous sessions, the researchers decided to create a separate session for practical parent-infant work.

The session starts by welcoming the infants to the group with a song. Time is spent practising the four elements of Theraplay® namely structuring, engaging, challenging and nurturing, and both parents are encouraged to actively engage with, and delight in, their infant. The aim of the session is to provide parents with basic, practical tools that could strengthen the parent-infant bond, lower anxiety and enhance self-efficacy and esteem (Munns 2011; Rumley 2004).

The programme concludes with a joint picnic where couples can share some time as a family, as well as with couples who they have come to know over the seven weeks, and this presents an opportunity to say goodbye to fellow group members and reinforces the idea that interacting socially or connecting as a family could be as simple as sharing a meal in a relaxed setting.

At the conclusion of the programme, follow-up therapy with suitable healthcare providers will be recommended (Vigod et al. 2016) to vulnerable couples and their families that may need a longer term intervention.

Discussion

The researchers set out to develop a programme for couples who experience PND, with the aim of addressing gaps in research as highlighted in the literature. The aetiological factors leading to the development of PND are complex, and this has implications for the efficacy of interventions focussed only on mothers and specific symptom profiles (Dennis and Hodnett 2007; Lyons-Ruth et al. 2000; Melrose 2010). Researchers advocated for the development of more integrative, holistic programmes, that could be tailored to the specific needs of each individual (Hunt 2006; Solomonov and Barber 2016) and focus on the parental relationship and the family rather than on the individual (Clatworthy 2012; Mulcahy et al. 2010; Paulson and Bazemore 2010).

The structure and content of the *Building Blocks* programme was informed by data gathered from three sets of reliable sources. Firstly, a thorough analysis of the literature was done and the researchers identified the couple's relationship as an emerging point of interest in the treatment of PND. Secondly, couples who were experiencing maternal PND were interviewed regarding their parenting and PND experience (Ferreira and van Rensburg *a* in review). A preliminary programme was compiled based on the data gathered from these two sources. Thirdly, the preliminary programme was then submitted to a panel of experts working in the field of PND for evaluation, and the data gathered in this phase (Ferreira and van Rensburg *b* in review) was used to refine the content and quality of the programme.

The *Building Blocks* programme was designed as an integrative intervention programme for couples who were experiencing maternal PND, with the aim of alleviating the symptoms and the impact of PND on the individual as well as the bigger family system. The programme integrates methods from different schools of thought that have been achieving positive outcomes in the treatment of PND, namely: a group intervention with elements of

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supportive therapy, CBT, BMT, psycho-education and Theraplay® (Beevers 2011; Craig et al. 2005; Jernberg and Booth 2001; Lukens and McFarlane 2004; Meki 2014). The benefit of an integrative approach is that the intervention is flexible and can address the unique needs of each individual (Lazarus 2005). Some essential elements needed for inclusion in a postnatal parenting programme for couples were however identified through the analysis of existing literature, interviews with couples who experience maternal PND (Ferreira and van Rensburg *a* in review) and the evaluation of the programme by a panel of experts guided by the Delphi method (Ferreira and van Rensburg *b* in review) namely: support/debriefing; knowledge (psycho-education); cognitive restructuring and practical skills acquisition.

Poor partner support is one of the strongest predictors of postnatal depression (PND) (Clatworthy 2012; Dalfen 2009; Dennis and Ross 2006; Grigoriadis and Ravitz 2007; Milgrom et al. 2006a; Mulcahy et al. 2010; Venis and McCloskey 2007). The main difference between this programme and other existing PND programmes is the inclusion of both partners throughout the intervention. This is in line with recommendations by researchers in the field (Clatworthy 2012; Mulcahy et al. 2010; Paulson and Bazemore 2010) and is viewed as a strength as it mobilises more resources of support for both partners during a period where it is desperately needed. Furthermore, experts in the field, highlighted the need for increased social support and indicated, that if a programme were to be perceived as offering a supportive space it would strengthen couples' commitment to attend the programme (Ferreira and van Rensburg *b* in review). The researchers included elements in the programme that focus specifically on building cohesion among group members, but also strengthening the couples' relationships. It is therefore believed that this programme will be successful in meeting the first essential need of emotional support.

The second essential need pertains to the imparting of knowledge. Researchers in the field strongly recommend psycho-education and the provision of information to parents who

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experience PND (Letourneau et al. 2011; Lyons-Ruth et al. 2000; Vigod et al. 2016). Experts who participated in the Delphi evaluation however warned against information overload and recommended a good balance between the provision of information, discussions and support. The researchers adjusted the contents of the programme accordingly and also included notes for facilitators that advise the use of the manual as a guide only, and recommend tailoring of the programme according to the needs of the couples who attend the programme. This is in line with recommendations in existing literature (Hunt 2006; Solomonov and Barber 2016).

Experts who evaluated the programme highlighted the prominent experience of self-criticism and negative thoughts in parents who experience PND (Ferreira and van Rensburg *b* in review). This is corroborated by researchers in the field (Dalfen 2009; Leigh and Milgrom 2008; Seymour et al. 2014; Stein et al. 2009; Sword et al. 2012). The inclusion of a module on the connection between thoughts, emotions and behaviour is accordingly regarded as a vital part of this programme. This programme is unique in that both partners will receive the same psycho-education and skills training, and thus the researchers believe that this will enhance the couples' coping abilities. The need for cognitive restructuring as identified in the literature (Ferreira and van Rensburg *a* in review) and by experts who evaluated the programme (Ferreira and van Rensburg *b* in review) is addressed by this programme.

The fourth essential element that was identified for inclusion in a postnatal parenting programme pertains to practical skills. According to experts in the field (Ferreira and van Rensburg *b* in review), parents can become overwhelmed by the vast array of parenting duties. They state that it is vital to offer parents practical tools that could improve their coping abilities (Ferreira and van Rensburg *b* in review). The researchers therefore included practical tools into the programme that focus on the individual, and the couple as well as the infant. These include: relaxation training, communication skills, conflict management and parent-infant activities by means of Theraplay® principles. Relaxation training is an

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evidence-based behavioural technique that is especially effective in the treatment of anxiety (Australian Psychological Society 2010), one of the most prominent features of PND (Kleiman 2000). Furthermore, communication skills and conflict management are both evidence-based tools in enhancing closeness and reducing conflict in intimate relationships (Gupta et al. 2003). In addition, parents are equipped with practical skills to assist in creating a warm, nurturing environment for their children and also to empower them by addressing feelings of incompetence, an aspect that contributes to parenting stress, as identified in the couples' interviews (Ferreira and van Rensburg *a* in review) as well as in the literature (Liu et al. 2011). Experts who evaluated the programme (Ferreira and van Rensburg *b* in review), highlighted the inclusion of practical activities and tools as being a strength of this programme.

Finally, PND could have a far reaching negative impact on the mother, father, couple and infants (Dennis et al. 2012; Likierman 2003; Mulcahy 2010); therefore, the programme was designed with all members of the family in mind. By including both partners in the programme, the risks of the consequences of PND and the impact thereof on the family are reduced (Kane and Garber 2004; Reck et al. 2011). Experts in the field identified the inclusion of both partners as a unique quality and as one of the strengths of the programme (Ferreira and van Rensburg *b* in review). Furthermore, by including a parent-infant module as well as a practical session into the programme, the researchers aim to facilitate warm, attentive parenting as recommended by the literature (Jung et al. 2007) as a positive parent-infant experience could help improve the mothers' mood.

This programme meets the essential requirements of an integrative parenting programme for couples who experience maternal PND as identified in the literature, in terms of data gathered from interviews with couples who experience maternal PND (Ferreira and

van Rensburg *b in review*) as well as experts' opinion working actively in the field of PND (Ferreira and van Rensburg *b in review*).

Limitations

There are various limitations that relate specifically to the planning phase of the intervention. Finding parents for the couples' interviews was possibly the most challenging part of this project. A small sample size (13) could impact on the saturation of data gathered through the semi-structured interviews. Furthermore, the sample consisted of a heterogeneous group in terms of infant age spread over twelve months postnatal, and this could be a limitation as the age of the infant could result in specific challenges for parents. Finally, the group of parents was mostly homogeneous with regards to culture and socio-economic status, which could result in the programme content not translating well to diverse groups of clients.

Limitations were also identified with regards to the second phase of this project, during which the proposed programme was evaluated by means of the Delphi method. The group of healthcare professional from diverse training backgrounds and theoretical paradigms added value by providing a broad perspective on PND and the challenges encountered in working with this population. The diverse theoretical orientations however proved to be a limitation as well, in that professionals did not consider the broader spectrum of evidence based treatment options in their feedback, but strongly advocated for the use of their theoretical paradigm of choice. Despite the programme being based on a technical eclectic framework, the researcher found it challenging to incorporate these strong differing viewpoints.

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Other limitations could include practical challenges regarding childcare as both parents are included throughout the duration of the programme, as well as not addressing the needs of other children in the family system.

Recommendations for future research

Even though a lot of effort was put into ensuring relevance of this programme to couples who experience maternal PND, it is recommended that the efficacy of the programme be tested in future by evaluating maternal PND prior to and post intervention.

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**SECTION C: CONCLUSIONS, PERSONAL REFLECTION, CONTRIBUTIONS,
RECOMMENDATIONS, AND LIMITATIONS**

3.1 Introduction

Section C contains a reflection of the main findings, the implications of the findings are noted and recommendations are made for future research with specific attention to maternal PND and interventions focussed on couples.

3.2 Conclusions from the literature

Research is inconclusive regarding the exact etiology of PND (Wiklund, Mohlkert, & Edman, 2010), it is however clear that multifaceted factors interact and contribute to the development of PND in vulnerable individuals (Melrose, 2010; Morrissey, 2007). These risk factors include biological, psychological and sociological elements, and presents in unique ways in each individual who develops PND (Milgrom, Martin, & Negri, 2006).

Due to the central role of the mother in the family system, her inability to cope has serious implications for her own emotional health, the care and development of her baby, the marital relationship and the family as a whole (Mulcahy, Reay, Wilkinson, & Owen, 2010; Dennis et al., 2012). If left untreated the impact of PND could have long-term negative consequences for the wellbeing of each family member, and could last well beyond the first year postpartum (Siu, Chow, Kwok, Li, Koo, & Poon, 2011). Therefore, it is essential for more research to be done in an attempt to find effective intervention strategies to assist in the treatment of families suffering from PND.

Dennis and Hodnett (2007) postulates that no single intervention, focussed on one element of PND would effectively treat the complexities, mothers, couples and families face when experiencing maternal PND. In the light thereof, previous researchers recommended the development of integrated treatment plans, that focus on the whole family, and can be tailored to the specific needs of each individual (Hunt, 2006; Kane & Garber, 2004; Kathree & Petersen, 2012; Solomonov & Barber, 2016). Researchers have found that including both

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parents in an intervention could address the needs of all family members at the same time, and lead to better long-term outcomes (Kane & Garber, 2004; Reck et al., 2011).

Relationship-based intervention for PND have achieved positive treatment outcomes (Clatworthy, 2012; Page & Wilhelm, 2007) and researchers motivate for more research focussed on the couples' relationship as a protective factor (Clatworthy, 2012). The inclusion of fathers in interventions for maternal PND is therefore considered as essential.

3.3 Conclusions from the current study

Article 1

The first objective was to explore how couples in a South African setting experience maternal postnatal depression. This was done with the secondary aim of identifying necessary elements to include in an integrative parenting programme for parents who experience maternal postnatal depression, with the purpose of developing such a programme.

The results show that the effect of PND manifests on a physical, psychological and interpersonal level, and has a negative impact on all members of the family system, this corroborates previous research findings (Goodman, 2004). The researcher identified elements to include in a parenting programme by doing an analysis of literature in the field of PND, exploring the efficacy of existing interventions and interviewing couples who experience maternal PND.

From the data gathered in addressing the first aim, four categories of essential needs emerged, namely the need for: support; psycho-education; cognitive restructuring and practical skills. Furthermore, it became clear that an effective intervention would have to focus on addressing the needs of all members in the family system, this is supported by previous research (Clatworthy 2012; Mulcahy et al. 2010; Paulson & Bazemore 2010). The researcher chose to work from a technical eclectic paradigm (Corey 2005) in order to compile

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a holistic programme that would focus on all the identified needs and could be adjusted according to the needs of each individual, as recommended by the literature (Hunt 2006; Solomonov & Barber 2016).

Article 2

The proposed parenting programme was presented to a panel of experts for critical evaluation regarding the programme content and structure. This was done by utilising the Delphi method, with the purpose of refining the content and quality of the programme (Skulmoski, Hartman, & Krahn, 2007). Experts commented on the structure, content, process, strengths, limitations as well as challenges of the proposed programme. The evaluation by experts with experience in the field of PND, helped in illuminating blind spots and creating awareness of the challenges that professionals encounter when working with this vulnerable population. Aspects that were highlighted included issues that would affect the feasibility of the programme; factors that would have an impact on the groups cohesion, sense of safety and couples' willingness to engage in the process; and the importance of not adding to the parents' responsibilities and expectations, but offering participants something useful and practical. This assisted in making the content as well as the structure of the programme more relevant to the population it is intended for. The critical evaluation by experts served to refine the programme for final compilation and dissemination.

Article 3

In the third article the researcher reports on the finalised programme. The programme was designed according to the knowledge base available in academic literature, the needs of couples who experience PND as identified through semi-structured interviews and expertise knowledge of professionals actively working in the field. The researcher incorporated

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evidence based techniques from different theoretical frameworks that has proved effective (Gold 2002; Lazarus 2005) in the treatment of the identified essential needs, as well as PND in particular. This includes elements of supportive group therapy, psycho-education, CBT, BMT and the principles of Theraplay®. The programme focus on the needs of all members in the family system, but is specifically focussed on strengthening the couple's relationship. This is achieved by educating both partners on the nature of PND; providing couples with tools to combat negative thinking patterns; improving communication between the partners; reducing destructive conflict and enhancing intimacy. By strengthening the couple's relationship, the amount of support available to both partners as well as the children increases, and could benefit the family system as a whole (Kane & Garber 2004; Reck et al. 2011). The participation of both partners throughout the programme is viewed as a strength by both the researcher as well as experts in the field of PND.

The essential requirements of an integrative parenting programme for couples who experience maternal PND as identified in the literature, in the data gathered from interviews with couples who experience maternal PND (Ferreira and van Rensburg *a* in review) as well as from the opinion of experts working actively in the field of PND (Ferreira and van Rensburg *b* in review) are addressed by this programme. It is therefore envisioned that this programme would be effective in treating couples who experience maternal PND.

3.4 Personal reflection

The researcher is the primary instrument in collecting data in qualitative research (Merriam, 2009), and learn from peoples' experiences by engaging with them on a personal level (Bloomberg & Volpe, 2012). Therefore, it would be of benefit to include some personal reflections.

Finding willing participants to share their experience with the researchers was an extremely challenging part of this process. Not only did couples feel hesitant to engage in the process, but healthcare professionals also seemed very protective of their clients or patients, and were reluctant to refer couples for research purposes. Couples seemed concerned that their parenting skills would be judged or that they might be perceived as bad parents. This is similar to the experiences of other researchers who attempted interviews or interventions with individuals or couples suffering from PND (Buzzard-Speights, 2012; McLoughlin, 2013). Many of the couples who agreed to participate mentioned that they wanted to contribute in order to help others who suffer from PND, as they had found it frustrating and difficult to find help when they needed it.

Each couple had a unique journey that brought them to the experience of PND, some experienced birth complications and trauma in the perinatal period and noted that their depressive symptoms started before the birth of their infant, others experienced trauma related to serious health complications in both the mother as well as the infant. Some parents felt overwhelmed and lacked coping resources to deal with the new roles and responsibilities, many experienced relationship problems and financial stress also seemed to play a central role in emotional distress. With most couples it was clear that the mother takes on more of the childcare responsibilities. There were however mothers who reported that their husband were very active and supportive in childcare and household duties. This highlighted the complex nature of the aetiology of PND.

Despite the difficulties experienced by couples in this study, most parents emphasised that their children were not the source of their depression and that they viewed them as blessings. These are important aspects to keep in mind when planning PND interventions.

3.5 Contributions made by this study

This study made contributions on three levels. Firstly, on a theoretical level, the study helped to broaden the theoretical knowledge base pertaining to maternal PND as experienced by couples. This was achieved by interviewing couples who experience the impact and challenges that goes with the PND. Futhermore experts in the field shared knowledge from their professional experience. This adds theoretical value in that it highlights what experts have found to be effective in the treatment of individuals and couples who experience PND as well as the challenges they encounter when treating people who experience PND.

The study also contributes on a therapeutic level in that it offers a new parenting programme for couples who experience maternal PND. This programme can be modified to be used in individual, couples and group therapy. It is based on a sound theoretical base, includes evidence based therapeutic techniques that have proven to be effective in the treatment of PND, and has been evaluated by professionals who have extensive experience and a wealth of knowledge from working actively in the field. The study further adds value in that the programme can be used to train professionals in providing an effective intervention to individuals, couples or groups.

On a research level it highlights limitations and gaps in the research that should be explored in future and provide information that could be used in the development of additional intervention programmes.

This study further made positive contributions by providing couples who experience maternal PND with a space to voice their experiences and struggles, this served as debriefing, but also as an opportunity for parents to feel heard and hopeful that their experience could somehow make a difference in the lives of others suffering from PND. With regards to the experts who participated in the evaluation of the programme, this study contributed by giving experts a platform to add to the knowledge base of PND and to learn from the experience of

other professionals in the field. Feedback will be provided to these experts on the outcome and conclusions of this project and will offer them valuable and useful information that could be applied in practice.

3.6 Implications for clinical practice in South Africa

Prevention of PND.

It is clear that PND is a serious mental healthcare problem, with a prevalence as high as 34.7% recorded by previous researchers (Peltzer & Shikwane, 2011). As mentioned the impact of PND result in longterm negative consequences for all members of the family system (Wiklund et al., 2010). It would therefore be important to improve prevention strategies in primary healthcare services. This could be done by requesting mothers to complete the Edinburgh Postnatal Depression Screening scale during a visit to the baby clinic as standard practice and referring at-risk mothers for therapy.

The importance of identify risk in the perinatal period.

As depression could already develop in the antenatal period (Clatworthy, 2012), it could be beneficial to also screen mothers for depression when they attend ante-natal classes. Including modules on postnatal depression and identifying risk factors in the peri-natal period could assist in preventative care.

Inclusion of partners in interventions.

Research emphasise the importance of healthy partner relationships in the prevention and also speedy recovery from PND (Dennis & Hodnett, 2007). Furthermore researchers noted that fathers can also experience emotional difficulties in the postnatal period (Wee, Skouteris, Pier, Richardson & Milgrom, 2011) and should therefore be included in interventions.

Group therapy to enhance support.

A major contributing factor in developing PND is a lack of support. Offering PND interventions in group format could help combat the feeling of isolation and also diminish the stigma attached to PND (Craig, Judd, & Hodgins, 2005; Misri, 2006; Ugarriza, 2004). It is also a cost effective intervention that would be more accessible to parents of all socio-economic backgrounds (Scope, Booth, & Sutcliffe, 2012).

Utilising a multidisciplinary approach.

Few women reach out for help when they experience symptoms of depression in the postnatal period. This is likely due to a lack of knowledge about PND (McLoughlin, 2013), as most mothers think they are experiencing normal baby blues; or to the stigma attached to PND. Mothers would most likely not consult with a doctor for treatment for depression, it is therefore important for all healthcare professionals to have adequate knowledge about PND and evidence based treatment options that are available, so that mothers who are at risk of developing depression can be identified at baby clinics and referred for help.

Being mindful of cultural aspects that could affect early diagnosis.

It is important to consider cultural factors when consulting with mothers of new babies as certain cultures do not have words for depression and might not identify with the typical Western criteria for depression (Cox & Holden, 2007). These vulnerable mothers might not receive the care they desperately need. It is important to not only use a screening scale when looking for symptoms of depression, but to rely on clinical judgement when interviewing mothers.

Providing education.

Stigma is a social relational construct (McLoughlin, 2013) and prevents individuals, couples and families from getting the help they need. Community education with regards to the nature and risk factors of developing PND is essential in creating awareness of a preventable and treatable illness.

3.7 Limitations**Limitations with regards to couples who participated in the project.**

Due to a small sample size the data saturation could be affected, and data gathered is limited to the experience of heterosexual, middleclass couples who are either married or cohabiting. Furthermore, the sample lacked adequate cultural diversity. The challenge in finding willing research participants who experience PND is not unique to this study, other researchers in the field have encountered similar difficulties and had to adjust their research projects accordingly (Buzzard-Speights, 2012)

Furthermore, the use of semi-structured interviews might have been a limitation as there were parents who wanted to offer more of their experience, but due to requiring information pertaining to specific areas where problems may be encountered; and a lengthy semi-structured interview these contributions had to be curtailed.

The age of infants in the sample were spread over twelve months, and is viewed as a limitation as infants develop rapidly in the first year, and with each developmental stage parents may encounter specific challenges (Gladstone & Beardslee, 2002) that could contribute to PND.

Limitations with regards to couples who participated in the project

Professionals participating in the evaluation of the programme differed in their use of theoretical paradigms. Many of the professionals advocated very strongly for their theoretical orientation and did not consider other evidence based practices in their evaluation. This caused challenges in incorporating and integrating all recommendations.

Limitations with regards to the programme

Even though the programme content is based on interviews with couples experiencing maternal PND, experts working actively in the field and evidence based theoretical practices, the programme has not been tested in practice. The researcher however foresees difficulties in empirically testing this programme as it was extremely challenging to find participants for this project. Other researchers have recorded similar difficulties (Buzzard-Speights, 2012; McLoughlin, 2013).

3.8 Recommendations for future research

PND is not considered to be distinct from other depressive disorders (Hoertel et al., 2015). This poses a problem that could prevent couples from accessing the help they need. Because the birth of a baby is normally associated with joy and celebrations, mothers could fear that they would be judged and labeled as a bad parent for feeling depressed during this joyous time (Bilszta, Erikson, Buist, & Milgrom, 2010). Future should focus on exploring the perceptions of healthcare providers regarding PND as many parents in our study experienced healthcare providers as impatient and insensitive when they consulted for help regarding depressive symptoms.

Furthermore it would be beneficial to explore the difference in cultural experiences of emotional difficulties in the postnatal period.

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Finally, even though this parenting programme is based on existing research findings, the lived experience of couples, experts' opinion and sound evidence based therapeutic techniques, it is recommended that the efficacy of the programme be evaluated in practice, by assessing the parents' level of coping and functioning as individuals, couples and parents after attending the programme.

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Building Blocks

Participants' Manual



Content

Meeting 1: Information morning

We start the programme with an information session to provide you with all the details you require about this programme and also give you an opportunity to ask any questions you may have. This is also a chance to meet other couples who will be joining us for this programme.

Objective	Themes
Orientation	Basic orientation
Creating a sense of comfort and familiarity Building group cohesion	Getting to know you
Exploring the journey of parenthood Establishing commonalities among group members in order to build cohesion and decrease isolation	Myths The dream, the phantasy and the reality of pregnancy, birth and parenting

Meeting 2

- **Building Block 1: The Parenting Journey**

Objective	Themes
Exploring the journey of parenthood Establishing commonalities among group members in order to build cohesion and decrease isolation	Parenting is not always so easy...

- **Building Block 2: Psycho-education: Postnatal Depression**

Objective	Themes
Exploring the nature of postnatal depression	What is PND?
	What it is not: Myths
	The difference between baby blues and PND
	The symptoms of PND
To provide information regarding the vulnerability factors	Paternal postnatal depression
	What puts women and men at risk of developing PND?
To provide information regarding consequences of PND.	Why is it important to get help for PND? – PND and your children – PND and your relationship with your significant other
Increasing knowledge regarding treatment options	Treatment for PND – Therapy – The use of medication
Integration and clarification of information shared	Questions and Answers

Meeting 3

- **Building Block 3: The connection between our thoughts, emotions and behaviour**

Objective	Themes
To explain the connection between our thoughts, emotions and behaviour	The blueprint of our perceptions
To improve coping skills	To explore the difference between a demand and a preference
	Unhelpful concerns vs helpful concerns
	How our family of origin influences our blueprint
	How society influences our beliefs
	Dealing with negative thoughts anxiety
Integration and clarification of information shared	Questions and Answers

Homework for the next meeting: Answer the self-reflection questions on pages 47 in your manual

Meeting 4

- **Building Block 4: Parent needs**

Objective	Themes
Stressing the importance of self-care	How have I changed since becoming a parent?
Identifying needs in order to strengthen coping mechanisms	The things I require to feel fulfilled and centred in my life: Needs analysis.
Strengthening the support system	Obstacles in getting your needs met.
	Practical ways of getting your needs met.
Integration and clarification of information shared	Questions and Answers

Homework for the next meeting: Take some time before the next session to discuss the questions on page 49 with your partner.

Meeting 5

- **Building Block 5: Needs of couples**

Objective	Themes
Normalising experiences	Why do some couples experience a decline in relationship satisfaction?
Strengthening support system	You can contribute to a healthier, happier relationship.
	Aspects you can work on to strengthen your relationship: <ul style="list-style-type: none"> - Communication - Conflict resolution - Intimacy
	Identifying needs for the couple Reconnecting as a couple with children
Providing information on coping with PND as a couple	Postnatal depression and your relationship: <ul style="list-style-type: none"> - How can I get the support I need from my partner? - How can I help my partner who suffers from PND? - How do I cope if my partner has PND?
Facilitating closeness	You are still you.
	I am thankful.
Integration and clarification of information shared	Questions and Answers

Homework for the next meeting: Read pages 63 & 64. Do the letter writing activity, using the template provided.

Meeting 6

- **Building Block 6: Infant needs**

Allocate 10 minutes break for tea/coffee.

Start the group with a 10 minute Q&A regarding the previous meeting.

Objective	Themes
To help parents meet the needs of their baby	Creating positive interactions
To assist in fostering healthy attachment	Good-enough parenting
To enhance parent confidence and self-efficacy	Some easy and practical ways of strengthening the bond with your baby (Theraplay®)
	Structuring
	Engaging
	Challenging
	Nurturing

Meeting 7

Practical session and termination of programme

In the practical session the focus will be on practising the principles of Theraplay® as discussed in meeting 8.

Objective	Themes
Meeting the infants, strengthening cohesion	Welcome babies
Practising parent-infant skills	Theraplay® in action
Termination	

Introduction

Welcome to the Building Blocks workshop. As we embark on this journey I hope you will develop new awareness, gain knowledge and find ways of strengthening your support system so that you will have a more fulfilling and rewarding parenting experience. Maybe you will even develop friendships over the next couple of weeks with people who understand what you are going through; these friendships could be very valuable during your parenting journey.

Be open to receive, brave enough to risk.

Getting to know you

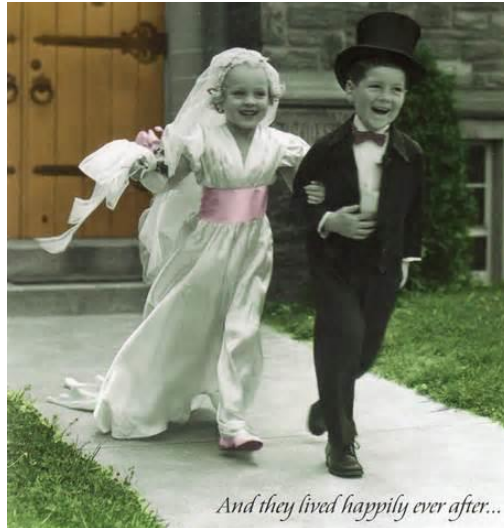
It is easier to share experiences, especially difficult emotional experiences with people you know and feel safe with. Let's start this discussion by getting to know each other. Tell the group about yourself, how many children you have, their age and gender. Also tell us what you hope to gain by attending this programme.

A bit of background on the purpose of this programme:

- The programme was designed for couples who suffer from PND
- About 15%-19% mothers worldwide experience symptoms of PND (O'Hara & McCabe, 2013).
- In South Africa the percentage is even higher, a study by Pelzer and Shikwane (2011) states that 34.7% of South African mothers suffer from PND.
- Research has highlighted the importance of the couple's relationship and good partner support in relieving depressive symptoms as well as helping the whole family cope during this challenging time (Dennis & Ross, 2006; Dudley, Roy, Kelk & Bernard, 2001; Edhborg, Matthiesen, Lundh & Widström, 2005; Pilkington, Milne, Cairns & Whelan, 2016; Pilyoung & Swain, 2007). That is why it is so wonderful that you are attending this programme as a couple. As a partner you can do a lot to support your significant other through this process. It is also a great opportunity for you as a couple to find ways to make this part of your life journey more rewarding.

We are going to focus on the reasons people develop PND, the symptoms people experience and also what will help ease your symptoms and increase your ability to cope with daily demands.

Building Block 1: Parenting



Let's talk about the myths about parenthood

Society portrays the expectance of a new infant as a time of serenity and joy (Milgrom, Martin & Negri, 2006; Mulcahy, Reay, Wilkinson, & Owen, 2010), but in reality it entails both positive and negative change and each parent has a very unique response to the news, and experience of both the phantasy and the reality of parenting.

Group activity: Group discussion

- Let's talk about what you expected, what you dreamed...and what you got.

Phantasies, Foetus, Birth, Real Baby

Parenting is not always so easy...

- *Your life changes completely. What has changed since you became parents?*
- *As parents you are bombarded with information regarding what is best for your child. How does that affect your ability to cope?*
- *If you have had a child, and adjusted your initial expectations and phantasies, does it get easier when you have more children?*
- *What works for one does not necessarily work for the others*
 - Each child is born with his/her own temperament.
 - You may have an idea of what kind of parent you would like to be, but your baby's personality will have a strong impact on how you will be able to parent.
 - Your baby's response to you is important feedback about your parenting but...
 - A "difficult" baby can make parenting a less rewarding experience and make you feel incompetent
(Milgrom et al., 2006; Nonacs, 2006).

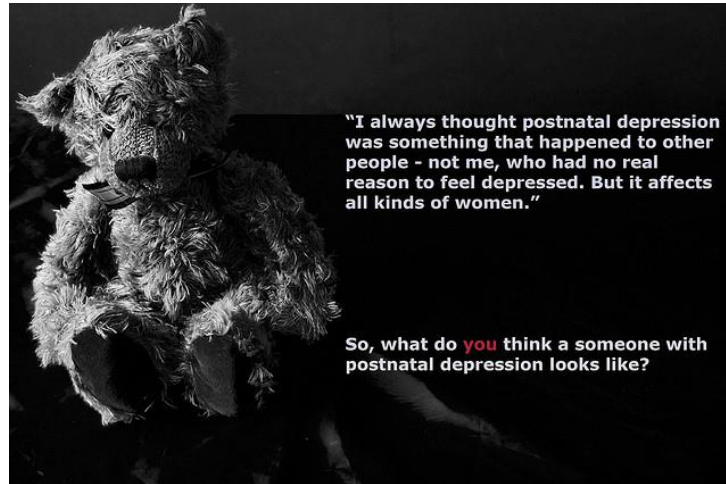
Each family is different

Every couple here faces different set of circumstances, strengths, and challenges, leading to a very unique parenting experience for each person, but due to various vulnerability factors, the group shares the experience of postnatal depression (PND).

In the next Building Block, we will look more closely at the nature of postnatal depression.

Thoughts and reflections

Building Block 2: What you need to know about PND



What it is... (Aarons, Levin & Taub-Da Costa, 2012; Venis & McCloskey, 2007)

- Depression is difficult to deal with during any stage of life, but the extraordinary challenges and demands a parent faces after the birth of a child, make postnatal depression unique.
- PND is real! If you feel something is wrong, then there probably is.
- It is not a sign of weakness.
- It impacts negatively on your own wellbeing, and that of your family as well as your experience with your baby.

What it is not: Faulty beliefs / Myths (Dalfen, 2009)

- It is normal to feel this way / it is not that bad.
- You are lazy / weak.
- It will go away on its own.
- It is something to be embarrassed about.
- It only happens to women.
- You are not ill, it is all in the mind.
- If people know what I'm thinking or feeling, they will take my children away from me.
- I'm not meant to be a parent / I'm a bad parent.

"And how are you?" said Winnie the Pooh.

Eeyore shook his head from side to side.

*"Not very how," he said. "I don't seem to have
felt at all how for a long time."*

From Winnie the Pooh, A.A. Milne



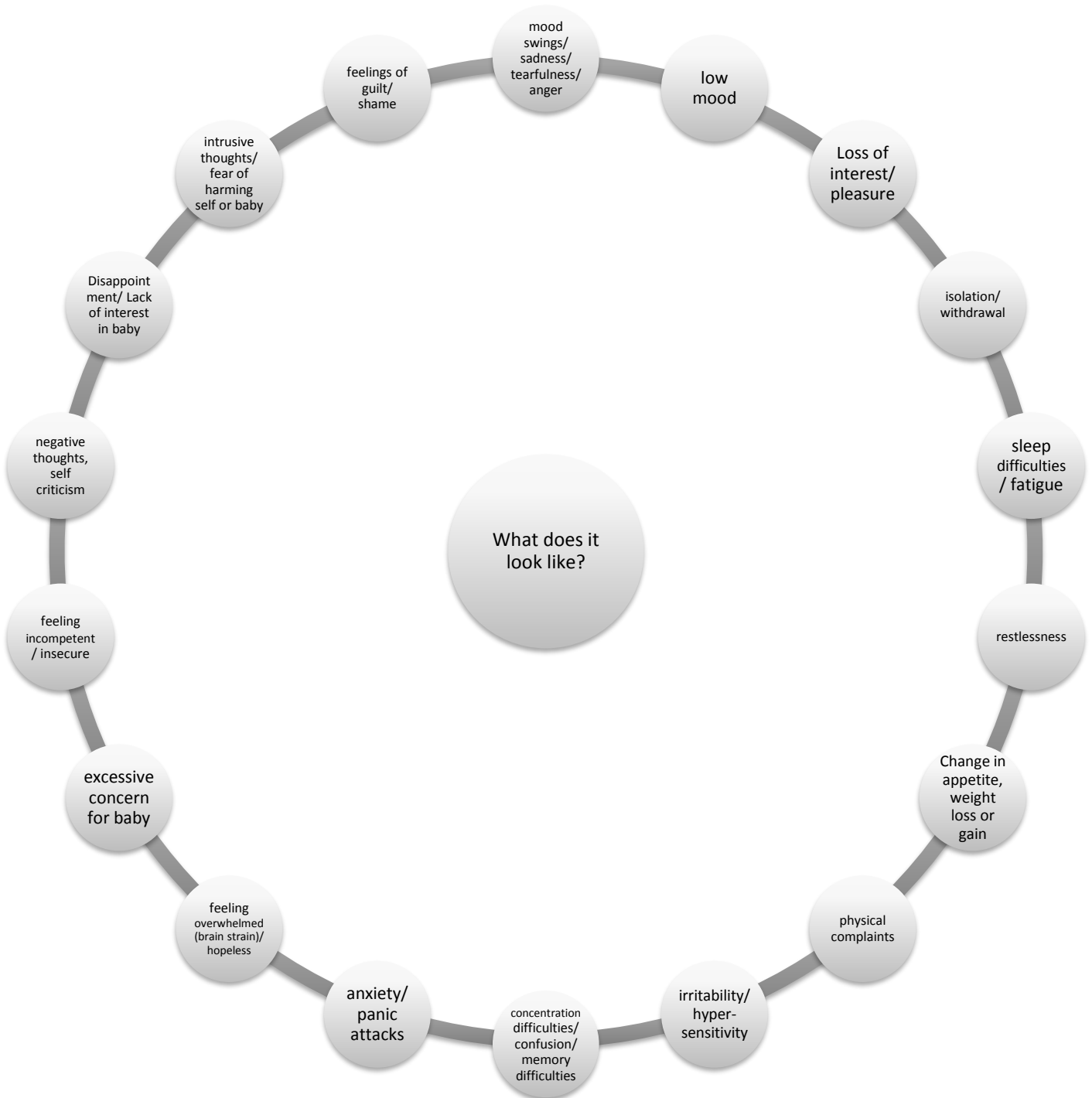
Difference between baby blues and PND

(Aarons et al., 2012; Dalfen, 2009; Nonacs, 2006; Venis & McCloskey, 2007)

The biggest difference lies in the intensity of the emotions and the duration of the symptoms.

Baby Blues	PND
Relatively mild highs and lows within the first two weeks postnatal. Tearfulness that starts roundabout day four after giving birth, resolves without intervention by day ten.	Can occur anytime within the first year after birth, or when the baby is weaned. There is little or no relief from negative symptoms. Symptoms last longer than two weeks.
Periods of sadness (come and go).	Intense sadness that does not go away.
Normal biological reaction, related to hormones that are released when milk is produced. (But some men suffer from it as well!)	Not only biologically based. Symptoms vary and these impact on daily functioning.
Negative feelings and thoughts that come and go.	Negative emotions outweigh positive feelings.
Some escape phantasies.	Avoiding your baby / thoughts about harming yourself or the baby.
Symptoms end rather quickly without intervention. Reassurance and support are helpful.	Professional intervention is required.
Symptoms do not interfere with daily functioning or care of the baby.	It is difficult to keep perspective on the bigger picture in life.
Feeling irritable and angry from time to time.	Intense irritability and anger.
Occasional worries that come and go.	Anxiety is always there, never goes away.
Poor sleep due to caring for your baby.	Cannot sleep, even when baby is sleeping, or want to stay in bed all day.
Fatigue.	Extreme exhaustion or agitation.
Normal fluctuation in appetite.	Overeating or loss of appetite.
Forgetfulness.	Serious difficulty in memory and concentration.
Limiting visitors.	Complete withdrawal and isolation.

Symptoms



(Aarons et al., 2012; Dalfen, 2009; Gottman & Gottman, 2007; Milgrom et al., 2006; Nonacs, 2006; Venis & McCloskey, 2007)

Paternal PND

Men can also suffer from Postnatal Depression!

When the baby arrives Dad could feel just as uncertain and incompetent as Mom (if not more). This on top of all the stresses to deal with along with sleep deprivation (Puryear, 2007) and worries about providing for the family (and perhaps deal with a depressed partner) could lead to postnatal depression in men! Men are just as vulnerable to developing PND as women, especially if there is a family history of depression. There is research that shows hormonal changes in men when their wives are pregnant. This interesting phenomenon could contribute to the development of depression (Misri, 2006).

Male PND symptoms look slightly different: men might not be as weepy as they tend to internalise feelings, they are more likely to present with tension or irritability and sleep problems / fatigue.

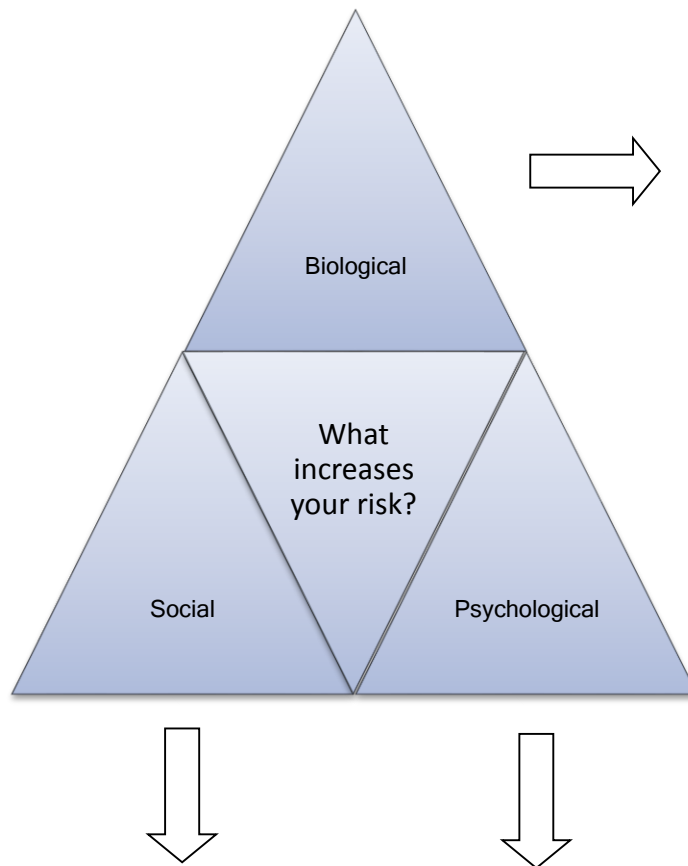
What puts women and men at risk of developing PND?

PND develops due to complex interrelated factors (Figueiredo & Conde, 2011; Melrose, 2010; Miles, 2011; Wiklund, Mohlkert & Edman, 2010), and the reasons people present with PND differ from person to person (i.e. what is stressful for one person may not be for the next person).

A combination of biological, psychological and social factors can make a person vulnerable to developing emotional difficulties postpartum (Dalfen, 2009; Venis & McCloskey, 2007).

i.e. A young girl, with poor support (social factors); who experiences birth trauma (Psychological); and struggles to breastfeed (Biological) or, a new parent with a history of depression (biological); who presents with poor self-esteem (psychological) and experiences financial problems (social factors) will be vulnerable to develop PND.

PND risk factors and causes



- Hormones
- Hormone-related mood changes / side-effects from oral contraceptives
- Breastfeeding/ weaning
- Thyroid problems
- Complications during pregnancy or birth
- History of mental illness
- History of Major Depressive Disorder
- Depression or anxiety during pregnancy
- Previous PND
- Pregnancy before physical or emotional recovery
- Postnatal pain or complications
- Other (previous abortion, stillbirth, loss of a child, fertility, HIV/ other medical problems)

- Quality of marital relationship
- Support structure
- Age (very young or more mature)
- Educational level
- Having a baby with special needs
- Having to care for more than one child
- Breastfeeding difficulties
- Financial problems
- Recent stressful life events
- Recent move
- External Pressure regarding parenting style/breastfeeding
- Shock of what parenting entails
- Being a single parent
- Fertility treatment
- Short hospital stay after delivery
- Lack of practical help
- Work-related stress

(Aarons et al., 2012; Dalfen, 2009; Gottman & Gottman, 2007; Milgrom et al., 2006; Nonacs, 2006; Puryear, 2007; Venis & McCloskey, 2007)

- Sleep deprivation
- Feeling overwhelmed
- Difficult birth/Birth trauma
- Unsatisfying birth experience
- Change in identity/ neglect of own needs
- Unrealistic expectations
- Anxiety
- Doubt about own abilities
- Excessive weight gain/body image problems / eating disorder
- Disappointment about baby's gender
- Baby is ill or disabled / has a difficult temperament.
- Personality factors (OCD, strong preference for routine/order)
- Poor self-esteem
- Negative thinking patterns
- Unwanted or unplanned pregnancy / ambivalent feelings towards pregnancy and infant.
- Own childhood experiences
- Sexual abuse
- Recent stressful life events

Why is it important to get help for PND?

You and PND:

The experience of PND could maximise the perceived challenges and minimise the rewards that goes with parenting, leaving you feeling unfulfilled and emotionally and physically drained. It limits your coping resources and impacts on your ability to deal with the challenges of parenting which in turn could make you doubt your capabilities and could also affect your self-esteem and aggravate the depression (Beck, 2001; Dennis & Hodnett, 2009; Lee et al., 2007; Leigh & Milgrom, 2008; Liu, Chen, Yeh & Hsieh, 2012; Milgrom et al., 2006; Nonacs, 2006; Venis & McCloskey, 2007). If left untreated, PND can last a very long time (Aarons et al., 2012) and therefore it is so great that you have decided to join this group.

Postnatal depression and your children:

When you are depressed, it may be difficult to be fully present and engage with your baby (Gottman & Gottman, 2007). You might find that you lack patience, energy and to be honest some moms even lack the desire to interact with their baby (Melrose, 2010) when they are feeling depressed and physically as well as emotionally exhausted. Some moms find it difficult to bond with their babies and feel overwhelmed by the demands that go with childcare (Aarons et al., 2012). Given these challenges, you can imagine that it will be difficult to meet an infant's needs when you feel you have nothing left to give! Your baby learns about him/herself, other people and the world by the way his/her caregivers respond to him/her (Nonacs, 2006), and so when you get help for PND, you also help your baby by being more available and attuned to your baby's needs.

Postnatal depression and your relationship with your significant other:

All people experience relationship difficulties from time to time (Gottman & Gottman, 2006; Nonacs, 2006). Experiencing depression could, however, make it much more difficult to deal with problems and conflict as your emotional resources are depleted. You and your partner may feel disconnected (Nonacs, 2006). Couples with children sometimes find it difficult to interact socially as they have a lot of childcare responsibilities and limited time. Some couples can become isolated and, having depression, you may not have the energy or the desire to engage with friends (Alici-Evcimen & Sudak, 2003; Dennis & Hodnett, 2009; Patel, Wittkowski, Fox & Wieck, 2013). Your significant other might feel helpless, frustrated even angry in the face of your depression, he/she might not know how to assist you through this difficult time and also feel overwhelmed if he/she needs to take on extra responsibilities at home, and may also start to feel depressed or anxious (Lee et al., 2007; Pinheiro et al., 2006; Venis & McCloskey, 2007). The couple's relationship will be discussed in a different Building Block, but it is important to note that a strong, healthy relationship could have a very positive impact on your mood and ability to cope (Dennis & Ross, 2006; Pilkington et al., 2016), and so it is wonderful that you are both attending this workshop!

Treatment for PND

It is important to note that PND is an illness (Aarons et al., 2012) not much different to Major Depressive Disorder and that it needs serious attention.

There are several treatment options available for individuals who suffer from PND. Some find that attending therapy alone brings a lot of relief, whilst others benefit more from medication and many choose a combination of medication and psychotherapy.

Therapy

According to Misri (2006) therapy has three goals:

- To understand the behaviour and emotions that contribute to depression;
- To address life events that may contribute to depression and help individuals cope with these events/stressors; and
- To empower individuals in coping with challenges by providing problem solving skills and techniques.

Kinds of therapy that could be useful:

- Individual therapy;
- Couples therapy; and
- Parent–infant therapy.

The use of medication

It is important to have a good trusting relationship with your Gynaecologist, GP or Psychiatrist as they could guide you in terms of the medication that will be right for you. Some people have reservations and fears regarding the use of medication.

Some people believe that using medication: (Dalfen, 2009; Nonacs, 2006)

- is a sign of weakness;
- won't fix the problem;
- might change their personality;
- will cause them to become dependent of the medication; and
- will harm their baby while they are breastfeeding.

Please discuss these concerns with your doctor as a lot of research has been done in the field and safe options are available! (Dalfen, 2009).

How does the medication work?

- It corrects the imbalance of neurotransmitters in the brain (serotonin, norepinephrine, dopamine) thereby relieving the symptoms of depression.
- It Improves your mood and sense of wellbeing so that you have more energy to deal with daily demands.

(Venis & McCloskey, 2007)

PLEASE NOTE: Medication takes time to work, you will not feel better immediately, but it will help you feel better in time. Compliance is essential for the medication to be effective (Aarons et al., 2012).

See a list of useful resources at the back of this manual. These will give you more help and information.

Thoughts and reflections

Your beliefs become your thoughts,
Your thoughts become your words,
Your words become your actions,
Your actions become your habits,
Your habits become your values,
Your values become your destiny.

Gandhi

Building Block 3: The connection between thoughts, emotions and actions

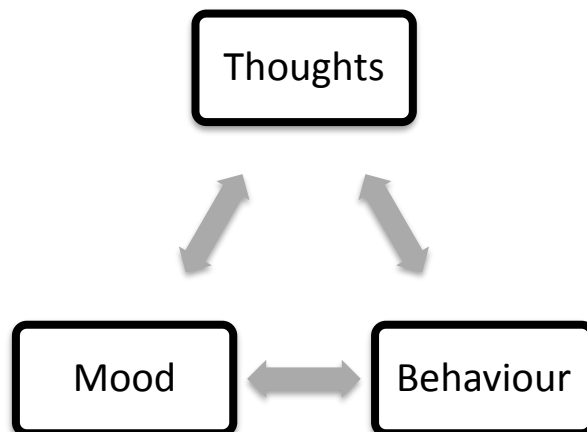
The blueprint of our perceptions

As discussed, there are certain factors that could make a person more vulnerable to developing Postnatal Depression. These factors include:

- Genetic predisposition;
- Personality traits;
- A psychiatric disorder;
- Early life experiences;
- Exposure to an ill parent / parent with dysfunctional coping skills;
- A poor social support network; and
- Lack of meaningful activities.

(Aarons et al., 2012; Dalfen, 2009; Gottman & Gottman, 2007; Milgrom et al., 2006; Nonacs, 2006; Puryear, 2007; Venis & McCloskey, 2007).

As we grow up, we develop a blueprint for our lives, a mental schema that dictates how the world, other people and we ourselves should function. This blueprint is affected by the vulnerability factors we have discussed and it affects the way we perceive our experiences, how we feel about them and how we respond to them. Our thoughts, emotions and behaviour are always interlinked (Milgrom et al., 2006).



To help you understand this let's look at some examples:

If I think: I cannot deal with these kids.

I will probably feel: Down and depressed.

And I will probably do: I will cry and not get out of bed and leave them to cry.

Let's stay with the same example:

I do: I let my kids cry and I stay in bed.

I think: I am a horrible mom.

I feel: More depressed and incapable of performing my duties.

Still the same example:

I feel: So miserable that I:

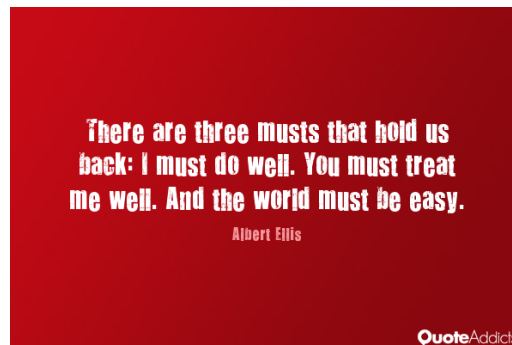
I do: Avoid my friends, do not answer my phone and do not ask for help.

I think: Nobody cares or understands.

I feel: Very sad and depressed.

Can you see how our thoughts, emotions and behaviour are constantly interacting? And how these could contribute to low mood or poor coping behaviour?

Demands vs preferences



Problems arise when our blueprint (Rules or thoughts about how life should be) is very rigid and we have certain **strict demands** which we impose on **ourselves, others and the world we live in** (Digiuseppe, Doyle, Dryden & Backx, 2014).

When we cannot keep to our own rules due to challenges beyond our control, or others break our rules, or the world does not seem to function according to these rules, we sometimes tell ourselves that it is the most **horrible** thing that can ever happen, that these rules are not being obeyed, and **I will not be able to stand it** if I/others/the world do not stick to these rules, and it will **say something bad about me/others or the world** if the rules are not followed.

We can see how these rigid demands can cause difficulties for a parent when we look at the following examples of **MUST** statements:

Regarding MYSELF

I **MUST** be the perfect mother for my children.

So one morning you send your child to school without a jacket and it turns out to be a very cold day.

If you hold on to the belief that I **MUST** be the perfect mother, a mistake like this one would make you think: I must be the perfect mother and the fact that I did not send a jacket is a horrible thing and it says that I am a terrible mother, I just cannot stand the idea. Can you imagine the emotional consequences for this mom?

How about we change the rigid demand to a **PREFERENCE**?

I would like to be the PERFECT mom, but that is not realistic because I cannot control everything that happens (i.e. the weather), so if I make a mistake or if I don't think of everything, it is perfectly human and it might cause inconvenience, but it will not be the end of the world and I will be able to deal with my mistake and its consequences.

This is the same example two different outcomes. The one mom will probably feel very anxious and criticise herself for failing as a mom, this in turn will affect her interaction with her child. The other mom will say, "Oh dear, better send a jacket with him/her next time just in case it gets cold". She will know it is not a reflection of her love for her child or her abilities as a mom but something that could have happened to anyone.

Another example could be for a dad who is struggling to make ends meet.

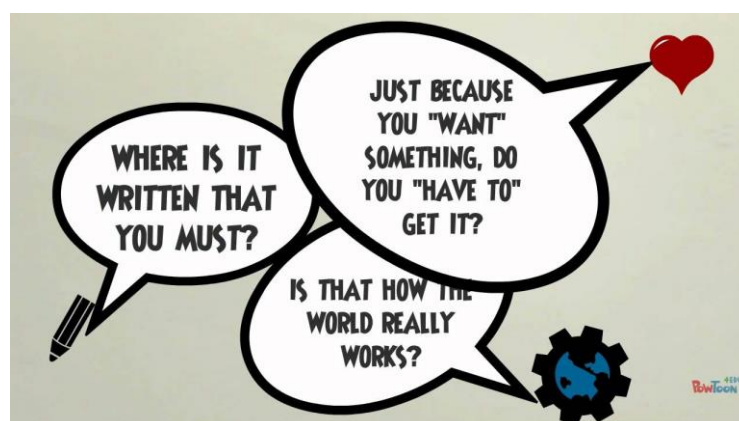
If the dad was raised to believe that it is the man's job/responsibility to provide for his family and this has now become a rigid demand. What will happen if this father is struggling to meet all the household and childcare demands on his salary?

I think: I am a failure as a dad.

I feel: Distressed.

I do: I cannot concentrate at work and I make careless mistakes.

If he could change his DEMAND that he HAS to be able to provide for all his family's needs to a preference: It would be nice to meet all their needs, but unfortunately I am only able to meet certain needs with a single salary, and that does not make me a failure as a dad, that just means we need to review the budget and work with what we have. This dad would be far more capable of meeting the emotional needs of his family if he spent less time being stressed about providing for ALL their needs at ALL times.



It is human to worry, but how do I distinguish between unhelpful anxiety or worry and helpful concern? The following questions could help you if you find yourself constantly worrying about something:

- Where is this belief (e.g. that I must ALWAYS be available for my baby) getting me? Is it helping or harming me?
- When you condemn yourself for not being the perfect parent /providing for all your family's needs, how does it help you be more effective?
- If I believe for example that my children should never get hurt, will it necessarily keep them from getting hurt or do things sometimes happen which are beyond my control?
- How is it true that because I feel useless / incompetent, I am useless / incompetent?
- Where is it written that... (e.g. I should never lose my temper)?
- What do you do well, even though the situation is difficult?
- Where is the evidence that... (e.g. I will not get through this day)?
- When I think I am worthless, how does it make me feel, and how is that helping me?
- Is this thought or belief leading to those feelings I want to have?
- How is this thought / belief helping me to reach my goals?
(Digiuseppe et al., 2014).

Sometimes our expectations and beliefs about parenting stem from our own experience. Where did you learn how to be a parent?

Your own childhood experience has a very strong impact on your parenting style and relationship with your baby (Milgrom et al., 2006). Sometimes parents have the need to provide their child with experiences which are the opposite to those they themselves experienced, or they wish to heal their own wounds by providing the infant with the perfect or ideal childhood experience (Gottman & Gottman, 2007).

“What we feel about our children, the way we care for them, the style of education we ‘choose’, all this is heavily determined by the re-enactment of long-buried patterns”. Brazelton & Cramer (1990).

Answer the following questions in your manual:

What was it like growing up in your home?

What kind of parent was your Mom?

What kind of parent was your Dad?

What did you learn from your parents about being a parent and the role your partner should fulfil?

What do you do as a parent that reminds you of how you were raised?

Do you hold on to certain rules just because it is the way things were done in your family of origin?

Is this still working for you?

Thoughts and reflections

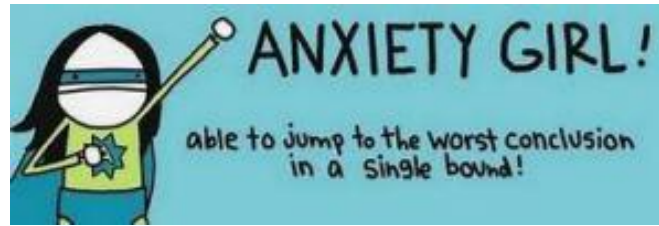
Couple Discussion:

- As a couple, discuss how your parents’ parenting style has impacted on your parenting.
- What core beliefs (beliefs you have learnt from a caregiver) may be contributing to burnout or difficulties within the family?

(For example: You might have had a very good upbringing with very devoted parents, now you believe you need to be the perfect parent but you have some challenges that make it difficult to achieve this goal. How is this belief that you need to be the perfect parent helping or harming you? / You might have had a negative parenting example growing up and now you have the need to establish the perfect relationship with your child, therefore perhaps believing that the infant needs to have every whim gratified and spared any frustration. How could this belief lead to difficulties within the family?)

At other times our expectations and beliefs about parenting stem from perceived expectations or pressure from society.

You could either open up the topic for discussion, or you could start the discussion by showing the “Best parenting video you will ever see” available on YouTube and the discuss the topic.



Dealing with negative thoughts and anxiety

“What a person thinks of a relationship may be more important than the interaction that actually occurs”. (Robert Hinde, 1990)

Negative thoughts

Negative thoughts translate into negative feelings and behaviour and these in turn reinforce a depressed mood. Depressed people see themselves as less effective and competent (Milgrom et al., 2006). This could narrow their focus and hinder effective problem solving. If you think of yourself as competent you are more likely to persist and persevere in the face of obstacles.

People who are depressed could become anxious as they could feel unable to deal with daily challenges. On the other hand, excessive anxiety could be a risk factor for developing depression (Mor & Winquist, 2002).

Some activities you may find useful in dealing with anxiety

Dalfer (2009) suggests the following activity

1. Identify the stressor, what is it about this event or situation that is stressful?

Find evidence to prove there is reason for concern/that shows the situation is actually not that bad. (You could use the questions on the previous page as a guide).

2. Remind yourself of other situations when you felt in control.
Make a list of people who would be able to help you if you needed help.

3. Manage the physical symptoms through relaxation and distraction.

Some more ideas from Venis and McCloskey, 2007:

Relaxation breathing:

- Sit or lie down comfortably and close your eyes.
- Focus on your breathing, try not to think of anything else but the sound of your breathing.
- Pace your breathing by counting each time you inhale or exhale; in-2-3, out-2-3.
- Gradually take deeper breaths until you fill your lungs to capacity.
- Continue for at least ten minutes.

Muscle relaxation:

- Sit or lie down comfortably and close your eyes.
- Mentally scan your body: start with your toes and work your way up through your legs, lower body, upper body, arms, hands, fingers, neck and head. Focus on each part separately, wherever you feel tension imagine the tension melting away.
- Now focus on each part of the body separately again by tightening the muscles in one area at a time, hold for five seconds, relax and move to the next body part. Continue tightening the muscles in all areas of the body while breathing slowly and deeply.
- Now imagine yourself in a place where you are at peace and relaxed, try to stay in the moment, imagining yourself in that special place, until you feel yourself relax.

We are now going to participate in a relaxation activity in the group.

PLEASE NOTE IT TAKES TIME TO LEARN NEW WAYS OF THINKING, SO IF AT FIRST YOU DON'T SUCCEED, TRY AND TRY AND TRY AGAIN... AND IN THE PROCESS BE KIND TO YOURSELF!!

Thoughts and reflections

Breathe

By Leo Babauta

Breathe.

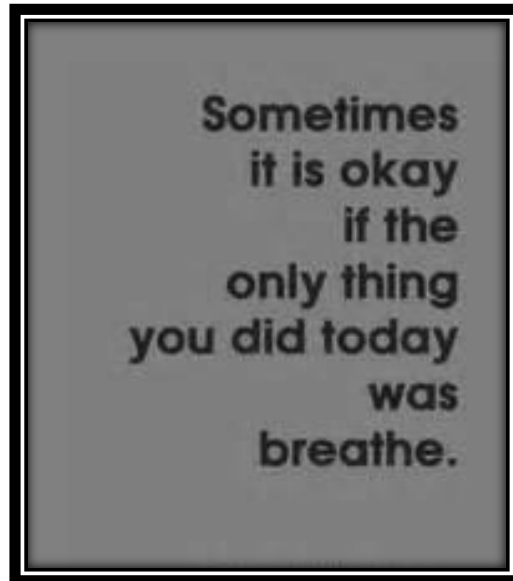
If you feel overwhelmed, breathe. It will calm you and release the tensions.

If you are worried about something coming up, or caught up in something that already happened, breathe. It will bring you back to the present.

If you are moving too fast, breathe. It will remind you to slow down, and enjoy life more.

Breathe, and enjoy each moment of this life. They're too fleeting and few to waste.

Building Block 4: Lets talk about your needs



One of the reasons why people develop depression is due to an imbalance between what they want for themselves (needs) and the reality they face (Digiuseppe et al., 2014). The demands of parenthood can be very overwhelming, but being a good-enough parent doesn't mean you have to sacrifice all your own needs and desires! Self-nurturing is extremely important in order to build resilience to cope with life's demands and provide for other people's needs (Puryear, 2007).

"To do my work well, I must feel fulfilled and centred in my own life".

(Puryear, 2007)

Individual activity: Reflect on the following questions and answer them in your manual.

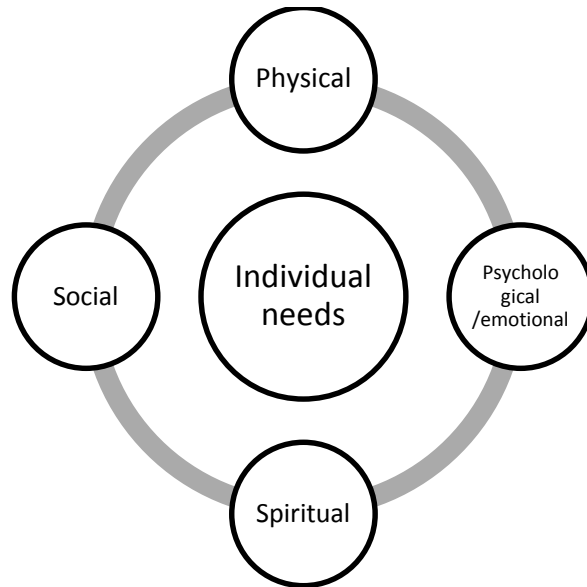
- How do you feel about your role as parent?
- Except for being a parent, what other roles do you have inside or outside your home?
- How have these roles been affected by you having children?
- How has your idea of yourself changed since having children? What do you like more / less about yourself now?
- How have your needs changed since you became a parent?
- Are there activities that you are no longer able to enjoy?
- Has parenthood had a negative effect on your relationships or your career?
- How, if at all, has your life been positively impacted, even in a small way?

(Nonacs, 2006)

Thoughts and reflections

Self-reflection activity

Take some time to make a list of the things you require to make you feel fulfilled and centred in your life and that would enable you to cope better. (Practical, emotional and informational / advice). Space is provided in the participant’s manual for notes.



Thoughts and reflections

What is standing in your way of getting your needs met?

How would you be able to take control of these obstructions, even in a very small way?

Who can help you meet these needs or enable you to meet these needs?

Practical ways to get your needs met

1. *Physical needs*

(Adapted from: Aarons et al., 2012; Dalfen, 2009; Nonacs, 2006; Venis & McCloskey, 2007)

• Take a break! Even if it means to just have a cup of tea.
• Sleep, try to stick to a regular routine. If this is not possible, ask someone to relieve you once in a while so that you can rest.
• Make sure you get good nutrition (a variety of whole grains, fruit and vegetables, lean meat and fish, avoid caffeine, alcohol, sugar and salt).
• Exercise (helps for general health, stress relief, mood and weight-loss).
• Get some help around the house if possible.
• Speak to a professional if you have problems breastfeeding.
• Help your body to relax, go for a massage or ask your partner for a massage, take a lukewarm bath or do a relaxation activity.
• Anti-depressants may be necessary

Taking care of yourself physically will energise you and help you to keep going.

Sleep / Rest is of utmost importance in dealing with depression.



- Sleep deprivation can lead to depression in someone who has no reason to feel depressed. It can also make problems you are normally able to solve seem insurmountable.
- This is one of the most important aspects in preventing or combating PND. Sleep alone could make a person feel more in control and able to face challenges.
- You need at least four to six hours of good uninterrupted sleep.
- Ask for help! So that you can get some rest.
- Take turns as parents to wake up for/stay awake with the baby.

- Have a sleep routine in place for your baby.
- If you are unable to sleep, do something relaxing. Do not fall into the trap of working when you are awake.
- Limit social visitors if you feel tired.

(Adapted from: Dalfen, 2009; Gottman & Gottman, 2007; Nonacs, 2006; Puryear, 2007; Venis & McCloskey, 2007)

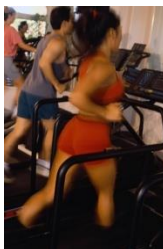
Nutrition



- Healthy eating helps you build up stamina.
- Don't forget to eat! If you have no appetite try comfort food or nutritional supplements.
- Include proteins (lean meat and fish), complex carbohydrates (whole grains), healthy fats (olive oil, avocado, fish oil), fruit and vegetables.
- Ask a family member or friend for help if you don't have time to prepare meals.
- Ask someone to help you with your shopping.
- Take vitamins and Omega-3 fatty acids.
- Limit the intake of caffeine and alcohol.
- Drink lots of water.

(Adapted from: Dalfen, 2009; Nonacs, 2006; Venis & McCloskey, 2007)

Exercise



- Helps you to lose pregnancy weight.
- Helps to elevate your mood, and to increase the “feel-good-hormone”.
- Helps with stress-relief.
- Serves as a momentary distraction from the stress you are experiencing
- Gives you energy, enhances self-esteem and confidence.
- Some parents enjoy activities that could include their baby.

(Adapted from Dalfen, 2009; Nonacs, 2006; Venis & McCloskey, 2007)

Commitment to self.

What changes am I prepared to make in order to take control of getting my physical needs met?



The most important part in the healing process is your relationship with yourself! Do I love myself and appreciate and respect my worth as person? Do I have GRACE for myself and do I treat myself with kindness?

2. Psychological / emotional needs

(Adapted from: Aarons et al., 2012; Dalfen, 2009; Nonacs, 2006; Puryear, 2007; Venis & McCloskey, 2007)

<ul style="list-style-type: none">• Increase self-nurturing activities. Take a break! “Me-time” is essential in order to replenish the depleted energy resources. Even a short “pause” from life would do you good. (Breathing exercise)
<ul style="list-style-type: none">• Have realistic expectations. Stop comparing yourself to others.
<ul style="list-style-type: none">• Cut down on unnecessary activities, simplify your daily routine.
<ul style="list-style-type: none">• It is okay to feel sad and mourn the loss of your previous life. Allow yourself time to cry.
<ul style="list-style-type: none">• Be realistic regarding time-management; be flexible.
<ul style="list-style-type: none">• Accept that not “perfect” but “good-enough” is good enough.
<ul style="list-style-type: none">• Monitor your self-talk. Challenge your unhelpful thinking styles. Increase positive thoughts.
<ul style="list-style-type: none">• Depression affects your feelings as well as your thoughts. Accept and express negative feelings.
<ul style="list-style-type: none">• Strengthen your support system, ask for help. Sources of support could include: your partner, extended family, friends, neighbours, co-workers, religious communities, a nanny, professionals and support groups (also on-line).
<ul style="list-style-type: none">• Be patient with yourself; parenting is a learned skill. Talk to other parents.
<ul style="list-style-type: none">• Learn to do something new, something you would enjoy.
<ul style="list-style-type: none">• Get as much information as possible to help you with your mood or childcare (preferably not Google!)
<ul style="list-style-type: none">• Avoid major life changes.
<ul style="list-style-type: none">• Focus on your individual and family needs, not the expectations of others.
<ul style="list-style-type: none">• Do something you love.
<ul style="list-style-type: none">• Have fun! Increase pleasant activities. Do something that is incompatible with feeling depressed.
<ul style="list-style-type: none">• What in your life is under your control? Start with a minor task, commit to doing it daily.
<ul style="list-style-type: none">• If you are back at work, see if you could ensure reasonable hours (both partners).
<ul style="list-style-type: none">• Find a routine that works for you. This will help you feel more in control.
<ul style="list-style-type: none">• Keep a journal.
<ul style="list-style-type: none">• Avoid isolation.
<ul style="list-style-type: none">• Cuddle / bath with your partner / your baby.

Going back to work / Balancing work and home life

- For some parents going back to work is a necessity due to financial pressure. Others find going back to work a welcome break from the demanding nature of childcare.
- Consider the costs and benefits carefully.
- It could unfortunately interrupt the schedule you have worked so hard to establish.
- It is important to find quality day-care so that you have peace of mind while you are at work.

(Puryear, 2007)

Commitment to self

What changes am I prepared to make in order to take control of getting my psychological / emotional needs met?

3. *Spiritual needs*

(Adapted from Venis & McCloskey, 2007)

- | |
|--|
| • Take a break! |
| • Find a spiritual anchor. (Praying, meditation, worshipping etc.) |
| • Connect to your spiritual community. |

<p>Commitment to self What changes am I prepared to make in order to take control of getting my spiritual needs met?</p>

4. *Social needs*

(Adapted from: Aarons et al., 2012; Dalfen, 2009; Puryear, 2007; Venis & McCloskey, 2007)

- | |
|--|
| • Isolation, alienation and lack of connection all contribute to depression. Strengthen your support system. |
| • Spend some alone-time with your partner. |
| • Phone a close friend or invite a good friend over. |
| • Spend time with other parents. Talking to other parents could enhance your parenting skills and build on your resources. Just remember there is no ABSOLUTE right way to raise your child. |
| • Start or join a playgroup / a support group. |
| • Join an online support group or start blogging. |
| • Arrange play dates for your kids. |
| • Get out of the house. |
| • Take regular breaks. |

Commitment to self

What changes am I prepared to make in order to take control of getting my social needs met?

Couple activity

Sit together as a couple and discuss how you could strengthen your support structure:

Kind of support needed (examples, add your own)	People / Places that could provide this kind of support
Tips/guidance on how to care for your child	
Babysitting	
Adult conversation	
Fun / relaxing activities	
Someone who believes in your abilities / makes you feel good about yourself	



Questionnaire

(Adapted from: Sherry J Duson as in Puryear, 2007)

How well am I taking care of me?

1. How is my appetite; did I eat regular nutritious meals today?
2. Have I slept at least five hours or taken a nap today?
3. How is my self-care? Have I showered or bathed today?
4. How much exercise did I get today?
5. Have I spent some quiet alone-time today?
6. Did I laugh today?
7. Did I allow others/ask others to help me today?
8. Did I show affection to my baby today? (hugs and kisses)
9. Did I talk to an adult about myself (not the baby) today?
10. Have I forgiven myself for the mistakes I have made today?

Thoughts and reflections

Building Block 5: We are in this together



*Hand in hand
we will grow
into the promise
of tomorrow,
taking with us
the enchantment
of this day.*

On becoming a family

Couple discussion:

How did becoming a parent affect your relationship?

Is there something that you miss about your life as a couple before you had children?

Raising children can be a very challenging. Research indicates, that after becoming parents, some couples report a decrease in the quality of their relationship (Condon, Boyce & Corkindale, 2004; Gottman & Gottman, 2007; Krieg, 2007; Schulz, Cowan, & Cowan, 2006). Why do you think this might be?

The good news is:

You can both contribute to a happier, healthier relationship.

We all experience stress and frustration from time to time which could contribute to relationship discord, but the demands that parenting bring could put a lot of extra pressure on both parents (Rode, 2016). Often couples feel unsupported, perceive their partner as being unreasonable or unfair, and become trapped in a blame game (Dalfen, 2009; Hendrix, 2008), it may be difficult for couples who are having relationship problems to create a healthy, supportive space between them. In order for the couple's relationship to be strong, both partners need to consider what they bring to the relationship that heals and supports and what they may intentionally or unintentionally be doing that leads to harm or discord.

The space between you as a couple could sometimes become polluted by what you say/do, or choose not to say/not to do. No one wants to be in a polluted space, therefore you may create exits that help you to avoid the polluted space, by working harder, sleeping more, basically doing any activity that could help you to avoid each other or the family space. This may cause one or both of you to feel isolated, unsupported and overwhelmed as you or your partner will have to deal with a lot of the childcare and household responsibilities alone. When you feel alone or excluded, you could come to feel overburdened or resentful, and this could lead to an unsatisfactory parenting experience (Shapiro & Gottman, 2005).

Individual activity:

Instead of looking at your partner's failings, consider for a moment how you affect the space between you. In what way do you strengthen the relationship or help to keep the space between you healthy? In what ways could you be contributing to polluting the space, even though you may not be doing it intentionally? Make some notes in your journal.

Thoughts and reflections

Some aspects you can work on that could strengthen your relationship:

1. Communication (Nonacs, 2006)

Good communication is vital in a healthy relationship and can strengthen a relationship. In a healthy relationship it is safe for each partner to express his/her thoughts and feelings. This can protect you or your partner from PND!

Focus on self: How do you communicate with your partner? Circle how you communicate, and reflect in your manual how you could help improve the communication in your relationship.

Interrupting	Ignoring	Blaming	Scapegoat
Victim mentality	Defensiveness	Sarcasm	Criticism
Name-calling	Belittling	Mind Reading	Bringing up the past
Threats	Counterattacks	Denying feelings	Giving up
Demands	Prescriptive	Disrespectful	Rigid
Silent treatment	Uncooperativeness	Withdrawal	

Thoughts and reflections

Part of your responsibility to keep the space between the two of you unpolluted is to refrain from making assumptions or jumping to conclusions, to communicate your needs effectively, without criticism, blame or judgement. Unfortunately, our partners do not always instinctively know what we need and we have to communicate our needs to them. The fact that your partner does not know what you need, does not say something about his/her love for you, it merely shows that the two of you have different perspectives on life. If you don't ask, you may just end up frustrated, without your needs being met.

Let's practise asking for what you need

Couple activity

Do you feel satisfied with your ability to take care of your child/ren? How can your partner assist you in being the best parent you can be? We are now going to practice effective ways of asking for the support that you require from your partner.

Roleplay – Communication

Remember you have a responsibility to keep the space between you free of pollution. Keep the following in mind:

1. Lay down some ground rules: No yelling or name calling; avoid judgemental or emotionally loaded words, avoid labels, no interrupting.
2. Do not treat your partner like the enemy; the aim is not to make your partner feel bad about him/herself.
3. Stay with one concern/need you would like to discuss. Focus on one issue and resolve it before moving on or ending the conversation. Stay in the present, do not bring old arguments into the space.
4. Be specific and clear – to the point, explain exactly what you need. Offer your partner some ideas of how he/she could help you meet your needs.
5. Ask for help, don't demand it.
6. Try to remain calm.
7. Try to understand the issue from your partner's point of view.
8. Avoid threats.
9. Try not to criticise.
10. Ask for clarity, don't guess what your partner thinks, feels or means.
11. Listen to your partner.
12. Remember to express appreciation.

(Dalfen, 2009; McKay, Fanning & Paleg, 2006; Nonacs, 2006).

Now try the following dialogue (Hendrix, 2008):

- Decide what you want to discuss
- The “speaker” explains clearly and to the point what he/she needs, without blaming, criticising or accusing.
- Try the following formula:
“I feel... when...and I would like to request ... If I am able to get this need met, it will help me to ...”
- The “listener” listens without interrupting and summarises his/her partner’s need after listening, in his/her own words. After summarising ask for any clarification if necessary or confirmation that you understood completely.
- The process is repeated until the sender feels the message was received correctly.
- The listener enquires whether there is anything else the speaker would like to add.
- Refrain from getting defensive, just LISTEN and try to see it from your partner’s point of view.
- End the discussion by describing why the “speaker’s” point of view makes sense and whether in principle he/she would want to help the “speaker” meet the mentioned need. Remember: saying something makes sense does not mean you necessarily agree with the other’s point of view, but it shows that you respect your partner’s difference of opinion.

The idea is not to convince each other of your point of view, but to create awareness and understanding of each other’s point of view (Gottman & Gottman, 2007).

2. Conflict

- Conflict could help you to understand each other better and is acceptable if it is constructive (respectful, gentle, taking responsibility for own part, listening, acknowledging).
- Clear communication is important when attempting to deal with conflict in a constructive manner.
(Gottman & Gottman, 2007; Hendrix, 2008).

Tools to manage conflict

- Keep the ground rules in mind! p.54
- Focus on what you have control over: yourself!
- Make time to discuss difficulties. Pick the right time and place.
- Stay in the present, focus on one challenge/issue at a time.
- Use the Imago dialogue: “I” statements. “I feel _____ when you _____”.
- Say what you feel, avoid accusations. Stay neutral avoiding blame, say what you need.
- Learn to listen, try to understand the issue from your partner’s point of view. (First strive to understand, then to be understood).
- Remember there are two realities at play here. Try to see the issue from the other’s perspective. Ask questions to understand your partner’s point of view. Validate your partner’s point of view.
- Accept responsibility for your behaviour.
- Offer solutions / ideas about how your partner can help you.
- Compromise (Your partner is not all bad and neither are you all good!). Sometimes we are afraid that if we compromise we will lose. Remember: this is not a battlefield.
- Trust your partner’s intentions.
- Take a time-out if necessary. (At least thirty minutes, no longer than a day).
(Dalfen, 2009; Gottman & Gottman, 2007; Nonacs, 2006; Venis & McCloskey, 2007).

3. Intimacy

We can distinguish between emotional intimacy and sexual intimacy. A couple needs to feel emotionally close to each other (emotional intimacy) in order to be able to experience healthy sexual intimacy. If you battle to communicate and experience increased conflict, you could find yourselves feeling detached and experience difficulty in connecting emotionally, which in turn could have a negative impact on your sexual intimacy (Gottman & Gottman, 2007).

You could have different expectations regarding intimacy after having children, while some people find their new role as parent incompatible with being a sexual being. Due to hormonal fluctuations and exhaustion; as well as the intense claims on the mother’s body if she is breastfeeding; and depression, parents could experience low libido, and decreased desire, passion and romance, which could lead to frustration and disappointment (Nonacs, 2006; Venis & McCloskey, 2007).

Sex is an important part of a relationship as sexual intimacy could help couples feel positive about each other and the relationship (Puryear, 2007). It is important to communicate your thoughts, fears and feelings regarding your intimate life to your partner.

Our needs as a couple

You may have marital difficulties unrelated to parenting issues; this is not the time to deal with those. The most important thing is to get the two of you to work as a team to ensure that you are both strong and healthy enough to provide your little baby with the love, care and nurturance he/she deserves (Aarons et al., 2012). Let’s take some time as couples to discuss what needs to change for you as a couple to create the best possible environment and atmosphere for your family. Use the skills you have learnt about communication and conflict management and as a couple write down what you would like to change in your relationship and what could help you achieve these goals. Focus on values, routine, rituals (holidays and celebrations), leisure time etc.

Thoughts and reflections

Handwriting practice lines consisting of 24 horizontal lines spaced evenly down the page.

Re-connecting as a couple with children

Even though your relationship could have changed a lot since you became parents, it does not mean that you can no longer have time to yourselves or have fun as a couple. It is important to strengthen your relationship as that will give you the energy that is required to face your daily challenges. Let's think of ways that you could bring joy into your relationship. Be creative! Think of activities or rituals that are free, cost-effective, some maybe more expensive. Also think of activities that require different lengths of time (i.e. going for a walk in your neighbourhood vs going on a date to the movies) and activities only for the couple as well as for the family as a whole (Markman, Stanley & Blumberg, 2010).

Some ideas from the literature:

- Make time for each other.
- Find time to talk. Talk about more than just PND or parenting.
- Stay in touch with one another; ask your partner how he/she is doing. Show interest!
- Try to go on a date regularly. Build and maintain friendship by doing things you both enjoy.
- Try to understand what your partner holds sacred (values, beliefs, experiences, symbols etc.).
- Show your partner that you value him/her. Express your admiration and appreciation for your partner.
- Focus on teamwork. Give support, show empathy.
- Show affection towards your partner.
- Talk about and make time for sex.
- Schedule family time: Bedtime stories, floor time, go for walks.
(Dalfen, 2009; Gottman & Gottman, 2007; Puryear, 2007; Venis & McCloskey, 2007).

Couple activity:

As a group we have now come up with some ideas of how to breathe life and excitement into your relationship. Some of these ideas may appeal to you, others not. Let's turn our attention now to your relationship and what will work for you as a couple.

- As a couple, write down some ideas of activities or rituals you will both enjoy and you feel will bring happiness into your relationship. Use the cards provided – *provide group members with cardboard cards* - to come up with fun ideas (at least 10! You can always add more cards later).
- Each partner should pick from the ideas three that you would enjoy most (it is okay to pick some that are the same).
- Hand these three cards to your partner.
- Each partner now takes responsibility within the next month for planning one of the fun activities or rituals your partner has chosen.

(Adapted from Markman et al., 2010)

Maybe you could make this a regular activity in your home?

Thoughts and reflections

Page 63 & 64 contain homework for the next session

PND and your relationship

Relationship difficulties represent a huge risk factor for the development and maintenance of postnatal depression

If I suffer from PND, how can I get the support and help I need from my partner?

If you are experiencing depression, the person who is closest to you will feel the negative effect of the depression.

- Help your partner to understand how you feel.
- Communicate your needs clearly; refrain from blaming.
- Give your partner ideas of how he/she could help you.
- Work on your relationship, bring the fun back.

(Venis & McCloskey, 2007).

How can I help my partner who suffers from PND?

- Get information. Try to understand the symptoms.
- Show that you care. Try to understand; be kind and patient.
- Don't label your partner.
- Don't take things personally.
- Ask your partner what she/he needs.
- Help identify needs.
- Your partner cannot be "talked" out of the depression, rather make time to listen.
- Make time to support your partner's needs, if possible take a few days leave.
- Don't add to the stress or pressure.
- Help in normalising the routine.
- Attend to other family members.
- Help identify sources of support. Get the help of a professional.
- Have realistic expectations.
- Plan some couple/family time.
- If your partner is suicidal or homicidal have him/her admitted to hospital.
- Take care of yourself.

(Misri, 2006; Venis & McCloskey, 2007).

Individual activity: Try writing letters to each other to help improve support and connection.

Example:

Dear...

I want you to understand how I feel...

This is how you can support me emotionally when I'm having a bad day...

These things you do mean so much to me...

These are concrete ways in which you can support me...

(Dalfen, 2009).

How do I cope if my partner has PND?

- Have realistic expectations. Recovery may be a slow process, but your partner will get better.
- Strengthen your support system, reach out to family or friends.
- Take breaks (also allow your partner breaks)
- Take care of your emotional and physical health.
- Work on your relationship.
- Set limits.
- Join a support group/talk to someone.

(Nonacs, 2006).

Even though your relationship may have changed a lot, the person sitting next to you is still the person you fell in love with. Many challenges have impacted on how you view each other and you may be struggling to see the good in your partner. For a moment, try to see past the challenges, frustration and conflict and try to see the positive qualities in your partner. Sit with your partner. If you are comfortable you may want to hold hands, and while the song plays try and remind yourself of the good in your partner.

“You are still you “– Josh Groban

Couple activity:

An important part of reconnecting with your partner is remembering to say thank you. Think of somethings you are thankful for and take a moment to express appreciation to your partner.

Building Block 6: What brought us here....

Needs of the infant

“Babies need parents who respond when they have a need, who soothe them when they are upset, calm them when they are frightened, and play enthusiastically with them when they are ready for fun.”

(Gottman & Gottman, 2007)

Creating positive interactions



A baby needs to develop a secure bond with at least one caregiver, and this bond develops over the first two years of your baby's life (Nonacs, 2006). The cycle of attachment (bond / special relationship between parent and infant) starts when the infant expresses a need by crying and the parent responds by meeting the need (Rubin, 2010). The infant teaches his/her caregiver about his/her needs and the caregiver guides the infant's exploration of the environment. Children who receive consistent warm, loving care from a caregiver learn that the world is safe and that their needs will be met; they develop secure attachment, learn to trust, grow in confidence and learn to deal with stress and difficult emotions. They have good interpersonal relationships later in life, have the capacity to explore the world efficiently and autonomously, perform better at school and they show resilience (Venis & McCloskey, 2007).

The way you feel has a strong effect on your ability to form a secure relationship with your infant and therefore it is so important that parents take good care of their own emotional wellbeing. For some parents the knowledge that their infants are affected by their emotional wellbeing causes a lot of distress. Many individuals fear that they are not good parents. It is important to remember there is no such thing as a perfect parent. Caring for a child is a difficult, strenuous job! (Puryear, 2007). Luckily, to foster a secure attachment with your child,

you do not need to be perfect, you just need to be good-enough. “Good enough” parents get it wrong from time to time, but they try to repair the mismatch between themselves and their infant (Gottman & Gottman, 2007; Nonacs, 2006; Puryear, 2007).

Good-enough parenting



How do I help my baby thrive?

- Love your child, help create a safe space for your child, comfort, praise, enjoy and play with your children.
- Be sensitive to, and respond, when your baby has a need - physical, emotional or social.
- Be consistent.
- Try to stay emotionally warm and available.
- Take care of yourself: get help!
- Set realistic expectations, according to what you are capable of doing.
- Make use of the resources and support available to you.
- Learn new ways of interacting with your child like: infant massage, learn how to become attuned to your baby’s needs, have fun with your baby, join a parent-infant group. This could be such a rewarding experience that it could have positive effects on the parent’s mood. (See resources at the back of the manual.)
- When parents enjoy their infant, the baby experiences him/herself as likable and lovable, and in turn becomes more delightful to be with. This positive interaction also gives the parent feedback that he/she is loving and giving, resourceful, strong and competent. This has a positive impact on the self-esteem of both parent and baby, and helps the baby to develop a positive view of his/her parents and the world. Babies seem to enjoy it most when parents join each other in playing with their infant. (Gottman & Gottman, 2007; Nonacs, 2006; Venis & McCloskey, 2007).

It is important for both parents to interact with your baby because you both have a very unique role to fulfil!

Both parents have a direct influence on the child's physical, intellectual and emotional development, therefore, it is very important that both parents are actively involved in the care of their children.

- Moms tend to provide more containment.
- Dads normally introduce more energetic games and increased levels of stimulation and can be a base for learning about play and exploration.
- Two different ways of interacting (mom and dad) provide a broader base for cognitive and affective development.
- Mothers need to be aware that they are the "gate-keepers" between father and infant. They could either help enhance the father-infant attachment, or restrict the father from having time with and access to, the child.
(Gottman & Gottman, 2007).

Some easy and practical ways of strengthening the bond with your baby

The creators of a therapeutic technique called "Theraplay®" (Jernberg & Booth, 2001) have identified four activities that replicate the healthy parent-child relationship and are crucial in the development of a safe, secure bond with your infant. These activities will be discussed in brief and we will spend time practising each activity with your baby. Please note that depending on your unique circumstances you may require a lengthier intervention to help you develop a new way of interacting with your infant. Please discuss issues with your facilitator should you require information on a parent-infant therapist that will be able to guide you in this process.

The four essential activities for a safe secure bond with your baby (Jernberg & Booth, 2001): there are no rules for how often you need to do these activities, but you will see that it is very easy to incorporate these into your daily activities.

Task	Structuring	Engaging	Nurturing	Challenging
Aim	The infant learns that parents can be trusted and that they are predictable. Parents help their infant to make sense of their experiences.	To optimise the infant's level of engagement and attentiveness by providing enjoyment, surprise and stimulation.	The parents engage with their infant in a warm and comforting manner and the infant learns that his/her parents care about him/her and that he/she is lovable.	To infant learns that he/she is capable of doing things as parents encourage him/her to try something new/challenging.
Infant learns	My parents have got this! I am safe with them, they know what I need	I am special and important to my parents, they enjoy me. I am a lovable, acceptable human being.	I am loved, my needs will be met. I can trust my parents, they will be there for me.	I am capable; my parents believe in me.

Many of the suggested activities that follow would involve more than one Theraplay® dimension at the same time.

1. Structuring:

Your child needs to feel protected (Rubin, 2010). This is achieved by taking charge in setting boundaries to ensure the infant's safety and survival and to help the child learn about the world he/she lives in. The parent helps to structure the infant's world by being attuned to the infant's needs; this helps your child learn that you are trustworthy and predictable. You also help your infant to understand his/her own inner experience (Jernberg & Booth, 2001). When experiences are overwhelming for the infant, the parent "scaffolds" the motor, mental and emotional experience by recognising, containing, explaining and supporting the infant's experience (Joyce, 2005).

Activities for structuring:

- Attunement
- Swaddling: Snuggly wrapping your baby makes your baby feel warm and safe. It also protects your baby from the startle reflex and helps your baby settle down when overstimulated.
- Creating routine by counting before you do something (i.e. 1-2-3 lift, when you pick your baby up), or singing a bedtime song when it is time for a nap.
- As your child becomes older you will create structure by setting rules and limits (i.e. No! Don't touch that) but for now you just need to help your baby feel safe and secure.

Activity – Attunement (There is a nice video available on YouTube: “Creating secure infant attachment”. You can choose to use this or just discuss what is in the manual.)

What is attunement and how do I do it?

(Attunement can both help structure experiences and engage with your infant)

Your baby sees the effect of his/her behaviour on your face. You are the mirror in which your baby learns about him/herself, especially about his/her inner world. As a parent, your role is to see your baby’s behaviour and sounds as attempts to communicate thoughts and feelings.

Attunement is the way in which both the parent and infant regulate their own behaviour in relation to each other (Like a dance). Initially the parent needs to take the lead until the child is ready to become more autonomous and independent. A baby is not able to regulate his/her own feelings or emotions. If the infant is not comfortable (cold /tired) or distressed, he/she uses all the available internal resources (crying, kicking etc.) to try to reorganise the regulatory resources. While doing that, the infant cannot focus on anything else. When parents help their infant deal with these feelings (by providing structure), the infant is free to respond to his/her environment.

By reflecting to the infant what is observed (a frown, a shiver, a giggle etc.) the infant starts to learn about his/her inner experience. Without a person who can accurately recognize and respond to the infant’s emotions, the baby will experience his/her emotions as overwhelming. If the parent is able to give an accurate reflection of the infant’s inner world the infant feels recognized. If the infant can get his/her needs met in this way, he/she learns that he/she has moderate control over the environment. The infant thus perceives the self to be effective, and the caretaker as reliable, and the environment as positive, and starts to feel safe, understood and accepted (Rubin, 2010). This is the basic requirement for secure attachment to develop.



Learning to dance

(Gottman & Gottman, 2007)

Parents do not always have all the answers and they need to learn how their infants communicate through their behaviour.

How your baby communicates:

- Eyecontact, engaging with you: "I like what we are doing".
- Active protest: "I don't like what we are doing/what is happening".
- Actively engaging with an object: "I like playing or looking at this object".
- Passive withdrawal: "I don't like what we are doing and I don't know what to do about it".

It sounds easy but often you'll probably get it wrong... and that is okay. The parents' readiness and ability to see these communication mismatches and to adjust their behaviour accordingly is what matters most.

Signs of Overstimulation

Babies easily become too stimulated as their nervous system has not yet matured. They show this by:

- Looking away;
- Shielding face with hands;
- Pushing away;
- Wrinkling their forehead;
- Arching the back;
- Fussing;
- Showing a mixture of emotions; and
- Crying.

Repair

By allowing your baby to tune in or tune out, he/she learns that he/she has control over the environment, and this helps them to learn how to self-soothe. They may turn their heads away or suck on something to calm themselves down. We have to help our infants learn how to self-regulate.

- Be calm.
- Allow for a break to self-soothe, or else assist in this process.
- Allow the baby to suck on something.
- Hold your baby close.
- Soften your voice.
- When baby is calm, you can resume your interaction in a softer, less-stimulating way.
- Try imitating the baby.

Signs of repair:

- Contact;
- Calm face and breathing; and
- Relaxed body.

Through the process of repair the infant learns about communication and different coping skills. The infant also learns about his/her ability to control the environment.

Can you think of any other ideas or share what you are already doing that would be a structuring activity?

Thoughts and reflections

2. Engaging:

Engagement is the act of playing together and enjoying each other without necessarily having a goal or specific game in mind, just having fun (Rubin, 2010). You are the best plaything for your child and you have everything that is required to make engagement enjoyable (your face, hands and body). Your baby shows his/her eagerness to play through eyecontact, smiling and babbling. You can help your child to engage with the environment through talking/reading and play (Venis & McCloskey, 2007). Sometimes your baby may not wish to engage, but do not take it personally (Rubin, 2010). Babies who do not engage easily can be drawn into engagement through games such as peek-a-boo, this little piggy, pop cheeks etc. Remain energetic and enthusiastic for a while, give the message that it is fun being with your baby. It sometimes helps to try and engage at different energy levels, if your child does not seem to enjoy high energy levels, move to something that is still enticing, but involves lower energy levels (Rubin, 2010). Through engaging with your baby he/she learns to communicate, to share intimacy and enjoy personal contact (Venis & McCloskey, 2007).

Activities for engagement:

- Attunement: mirror your baby's sounds and expressions.
 - Look at your child as if you are seeing him/her for the first time: gaze into your infant's eyes, count body parts, find and admire beauty.
 - Make gentle eye-contact; talk to your child.
 - Use your child's name often.
 - Play games like: This little piggy, Beep-honk, Peek-a-boo, pony ride, busy bee.
 - Sing songs: Incy wincy spider, Humpty Dumpty, The wheels on the bus.
 - Rolling on an exercise ball.
 - Where's your...finger...toe...tummy (tickles).
 - Talk to your baby. Tell your child exactly what you are doing, you help create an environment where the child feels safe and learns a language.
 - Read to your baby (Venis & McCloskey, 2007), even if you are reading the newspaper or a magazine. Your voice has a magical effect on your baby and can teach your baby about emotions and the regulation (control) of these emotions.
 - Finger puppets.
 - Blow bubbles.
 - Bumping noses.
- (Jernberg & Booth, 2001; Steel, 2015; Warner, 1999).



Attunement as a way of engaging:

Babies adjust and respond to their parent's face and voice. To the baby there is nothing more exciting than the parent's face and the parent's voice. (Gottman & Gottman, 2007)

Infants mimic the parent's internal state by re-enacting the same physiological arousal patterns inside their bodies. (What happens when you are depressed or angry?)

5 Most intriguing faces:

- Mock-surprise (open eyes wide, raise eyebrows, open mouth)
- Smile
- Frown
- Empathy (mock surprise & frown)
- Neutral

Can you think of any other ideas or share what you are already doing that would be an engaging activity?

Thoughts and reflections

3. Challenging:

By encouraging the infant to try something he/she has not done before or not succeeded in yet, the infant learns that he/she can master the environment. Meet the child where he/she is now and move/stretch them a little bit more. This helps your baby grow and develop.

Activities for challenging:

- Walking on mom or dad's lap.
 - Swinging baby gently in your arms / in a blanket between two parents.
 - Airplane game.
 - Let your baby kick your hands.
 - Gently dip your baby to experience his/her body in space.
 - Stand in different places in the room and speak to your baby. See if he/she can find where the sound is coming from.
 - Lay your child on your chest and call his/her name, see if he/she can lift her head.
 - Gently pull your baby into a sit-up, while firmly holding the arms.
 - Track toys as you move these across their visual field.
 - Experiment with new textures or sensations.
 - Stick out your tongue, see if your baby copies you.
- (Jernberg & Booth, 2001; Steel, 2015; Warner, 1999).

Can you think of any other ideas or share what you are already doing that would be a challenging activity?

Thoughts and reflections

4. Nurturing:

Nurturing activities entail comforting your crying baby, soothing your baby when in distress and providing for your baby's basic needs (food, shelter, clothing). When you soothe, calm and reassure your infant you help your baby learn that he/she is worthy of love and care and that you will be there to tend to your child's needs. Your child will learn in time to internalise the soothing function that you serve.

Activities for nurturing:

- Feeding;
- rocking, holding, cuddling, dancing etc.;
- infant massage;
- singing;
- butterfly kisses;
- Rubbing lotion on your infant / baby massage; and
- Infant massage.

(Jernberg & Booth, 2001; Steel, 2015; Warner, 1999).



Physical touch has benefits for both the infant and the parent's mood. Physical touch also encourages more secure attachment to develop.

Can you think of any other ideas or share what you are already doing that would be a challenging activity?

Practical session

Welcome to our final meeting! And welcome to the little ones! Let's get to know the babies that have joined us today before we begin with "Floor time".

How to prepare for your floor time: (Rubin, 2010)

- Find a comfortable space (on the floor or on the bed).
- Minimise distractions.
- Don't force yourself to engage when you are not feeling up to it. Your child is very attuned to your emotions and will enjoy playtime more if you are relaxed and also able to enjoy your time together.
- Plan break time and announce it energetically: Floor time!! You could even have a song indicating the start of floortime and a song to end.
- You and your partner can play together or take turns.
- Start with one or two activities (five to ten minutes).
- It is a good idea to end with a nurturing activity as it will help your child relax and calm down.

Practising the 4 elements of Theraplay®

Structuring

We are now going to spend some time practising being "in-tune" with your baby. Sit comfortably on the floor with your baby lying in front of you. For a moment just observe your baby and allow your baby to observe you. What do you notice? If your baby seems very energised, you might want to help contain a bit of the energy by helping your baby control and calm his/her limbs. Now comment on what you observe and tell your baby what you see such as a yawn: "ooooh that is a big yawn, is Sammy tired?"; or if your infant is looking around and seems excited: "This is an exciting place, hey Debbie, so much to see!" If your baby struggles to settle down, you are welcome to soothe your baby by picking him/her up and voicing his/her distress: "That's okay, this is all very strange to you, hey Thabo". All you need to do is be a mirror to your child that reflects what he/she is feeling and makes the feeling okay. Use not only your words but also your tone and volume to reflect the emotions you observe. You are teaching your child about his/her inner experiences and how to regulate emotions.

Now we move from just observing to engaging.

Engaging

- Spend some time to really look at your child; make tender eye contact; mirror some of your baby's facial expressions and sounds.
- Now comment on your baby's features: "Look at these little fingers, lets count them..."; "You have the cutest little nose, let's see what happens if I press your nose...beep!"; "And this...what have we here? Is that a belly?" Tickle.
- Let's sing a song..." move your baby's body or gently tickle your baby as you sing, "Incy wincy spider".
- Lastly, let's gently bump noses, babies love seeing your face up close.

Now we are going to do an easy challenge

Challenge

- Put your hands against the soles of your infant's feet and give a gentle push; see if he/she pushes back.
- Use a piece of cotton wool and gently stroke your baby's body; see how he/she responds.
- Gently pull your baby into a sit-up; do this three times.
- Use a toy and see if your baby can track the toy over his/her visual field.

Lastly, we are going to end of by some nurturing.

Nurturing

Take turns to touch your baby and just delight in him/her. Give your baby gentle kisses and hugs, some of you might need to change your baby now. This is also part of nurturing; you are welcome to go ahead.

We have come to the end of the workshop. Are there any questions or comments?

We end this workshop off by sharing a meal together, if you have not done so already, remember to exchange numbers as you may be able to provide support to each other. Thank you for taking the time to attend and invest in your family.



Useful numbers (Gauteng)

PNDSA (Post Natal Depression Support Association) 082 882 0072 (not a 24 hour hotline)

SADAG (South African Depression and Anxiety Group) 0800 567 567 (24 hour hotline)

Also see Therapistdirectory.co.za; Psychotherapy.co.za

Therapists with a special interest in PND

Dr Adilia Silva	060 479 9823	Kensington
Dr Aliza Bilman	076 368 7958	Bedforview
Hasmita Hardudh-Dass	082 885 0738	Glenanda
Clare Harvey	076 473 8242	Dunkeld
Michelle Andrews	081 700 8334	Bryanston
Laura Skead	082 567 6039	Dunkeld West
Lauren McClurg	084 916 6346	Parkwood

Psychiatrists

Dr Feroza Arbee	011 590 9500	Parktown
Dr Lavinia Lumu	011 792 9400	Boskruin
Dr Carina Marsay	011 285 0026	Hurlingham Manor
Dr Antoinette Miric	010 350 0351	Saxonwold
Dr Ryola Singh	087 098 0457	Randburg
	Ext 5462	

Social workers with a special interest in PND

Sally Baker (offers groups)	082 584 0666	Bryanston
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