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## Abstract

**Introduction:** Diagnoses and symptoms of postnatal mental health problems are associated with adverse outcomes for women and their families. Current classification and assessment of postnatal mental health problems may not adequately address the range or combination of emotional distress experienced by mothers. This study aims to explore symptoms of mental health problems reported by new mothers and their experiences of being assessed for these.

**Methods:** In-depth interviews with 17 women in southeast England with a baby under one year old who experienced a postnatal mental health problem. Data were analysed using inductive thematic analysis.

**Results:** Women described a lack of identification with the concept of postnatal depression and felt that other forms of emotional distress were not recognised by the healthcare system. Women felt that support seeking for postnatal mental health problems needed to be normalised and that support should be available whether or not women were diagnosed. . Assessment needs to be well timed and caringly implemented.

**Discussion:** Identification and recognition of symptoms and disorders other than postnatal depression needs to be improved. Awareness of multiple types of distress needs to be raised both for women experiencing such distress, and for healthcare professionals, to enable them to support women at this time. Different approaches to assessment that include the range of symptoms reported should be piloted.

Keywords: postnatal mental health, postnatal anxiety, postnatal depression, screening, assessment.

## INTRODUCTION

Assessment and research on postnatal mental health has predominantly focused on the most common or severe disorders, namely depression and puerperal psychosis. However, recent research suggests anxiety and adjustment disorders may be as prevalent; for example, anxiety disorders and Post-Traumatic Stress Disorder (PTSD) combined may affect 16% of postnatal women [1, 2]. Maternal anxiety is detrimental to both the mother and the baby and has been associated with preterm birth and low birth weight, emotional and conduct problems, negative effects on cognitive and social development in children [3, 4]. It is therefore clear that we need to consider a range of possible emotional responses during the postnatal period, and how best to identify these. A number of issues are pertinent to this.

First, diagnostic criteria may not be optimally defined for postnatal women – either through ignoring common postnatal psychological problems [5, 6], or through including ‘symptoms’ that may be normal postnatal factors such as fatigue or sleep disturbance [7]. For example perinatal specific problems, such as parent-infant attachment disorders and childbirth-related posttraumatic stress disorder are missing from the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-V) [4, 8]. Furthermore, although the DSM-V has changed the onset specifier for depression in the postnatal period from the first four weeks postnatally to also include depression during pregnancy, it does not recognise later onset of symptoms, or specifiers for the anxiety disorders, obsessive disorders or hypomania. There is also evidence that existing categories do not capture important mental health problems; for example in a sample of mothers with unsettled infants (i.e., enduring sleep, settling and/or feeding issues) equal numbers of mothers (10.8%) were diagnosed with generalised anxiety disorder (GAD) as were diagnosed with an anxiety disorder not otherwise specified (ADNOS), defined as the primary symptoms not being associated with obsessive compulsive disorder (OCD), social anxiety, specific phobias or panic disorder [9]. All of these women experienced uncontrollable worry about motherhood or their infant, suggesting that a classification of a distinguishable maternally focussed anxiety disorder may be warranted [5].

Second, a diagnostic (according to DSM diagnoses) approach to postnatal disorders can ignore significant subclinical or transdiagnostic symptoms, meaning many women with substantial distress might not be identified [1, 9, 10]. Additionally, the symptoms required for diagnosis in the general population may be incorrect for diagnosis of postnatal women. For example, four of the nine symptoms of major depression in the DSM are: weight loss; sleep disturbance; fatigue; and concentration difficulties. These are likely concomitants of being a new mother [7] therefore current classifications of diagnostic disorders may need to be modified for postnatal women. Alternatively, a different approach to identifying the postnatal psychological problems outlined above could be explored. In order to do this we need to examine the range of symptoms women report and how women conceptualise their distress, as well as how best to assess these.

The aims of this study were therefore to 1) qualitatively explore the different psychological symptoms postnatal women experience and 2) examine which of these symptoms women had been assessed for or asked about.

## METHODS

### Design and procedure

As we were interested in a broad range of symptoms not specific to predefined disorders, we purposefully defined distress as “any postnatal psychological and emotional difficulties” in line with the expectation that mental health professionals are expected to recognise mild to severe mental health problems throughout the perinatal period [11]. We interviewed women who: had experienced distress (but were not currently distressed); had a baby less than one year old; and lived in southeast England. We did not specify a minimum time since delivery. Recruitment was via websites relevant to mothers (local postnatal group Facebook pages), advertisements in local National Childbirth Trust (NCT) newsletters and through instructors at local ante- and post-natal groups, who were asked to inform members of their groups about the study. All women who showed an interest in taking part by contacting us were sent further information about the study, and all subsequently took part. Interviews

were carried out within two weeks of first contact, at participants' homes (n = 15) or by telephone (n = 2) and lasted 25-80 minutes. Prior to the interview the study was explained again and written informed consent obtained. The interview schedule contained eight open-ended questions: six questions about symptoms experienced, one question about the impact of distress and one question about assessment (see Appendix 1). The results from these questions are reported here. Further questions about the individual and social context in which women's distress arose are reported elsewhere [12]. Ethical approval was granted by the host University.

### Data analysis

Data were analysed using inductive thematic analysis with a critical realist approach [13, 14] where the way in which participants made sense of their distress was emphasised. Interviews were transcribed verbatim. Transcripts were read multiple times to identify aspects of distress important to the participant. These identified sections were re-read and labelled with attention paid to how the themes clustered and related to each other. Once completed for the first interview, all codes and themes were examined by the authors. The process of coding and clustering was done for each interview before moving on to the next, to retain an idiographic approach to analysis. Once all interviews had been coded in this way, comparisons were made across interviews to determine weight, range and prevalence of themes. The authors agreed on an approach to analysis before this phase began. The first author discussed emerging themes with the second and third authors to ensure that a consistent and balanced approach was applied to the process of coding and clustering. Self-reflexive application of the process meant that the authors gave priority to the interviewees' accounts rather than their own personal or professional knowledge of the experiences of the postnatal period. Reliability was ensured by regular meetings of the authors where problematic issues, such as ambiguity in assigning codes, were discussed and resolved. Additionally, the list of themes was sent to participants to ensure they felt they were representative of their experience. Participants were allocated numbers to protect anonymity. Data were coded using NVivo qualitative data analysis software [15].

## RESULTS

Seventeen women aged 23-42 took part. The sample were predominantly white European (n = 16) and there was one Chinese woman. Eleven of the 17 women were primiparous and 7 had previously experienced what they considered to be a mental health problem. Information about previous diagnosis was not sought. Two women had completed GCSE level education; six had completed A level education; five had a degree or higher degree; four had completed professional qualifications. Eight of the women had vaginal deliveries (of these, two were assisted) and nine had caesarean births (of which three were planned). Age of babies at the time of interview ranged from 2 months to 11 months. Fifteen women reported that their distress emerged within the first six weeks postnatal and six women were referred to or requested psychological or psychiatric services. The sample is more fully described elsewhere [12].

Women's descriptions of symptoms of distress were collated on the basis of their responses to the questions 'Can you describe how you felt when you were experiencing distress?' and 'Did you feel bad in one way only, or did you experience different ways of feeling bad?' The most prevalent symptoms spontaneously described are shown in Table 1 with examples from the participants. The most frequently reported symptoms were feeling tearful and anxious. Tearfulness was not necessarily related to feeling low but with various emotions or situations such as frustration and feeling unable to cope. Feelings of anxiety were reported by two thirds of women and were described as relating to the new mothering role, the health of mother and baby or a general state of arousal that mothers could not find a specific reason for.

Less frequent symptoms that were reported in under half of the sample were: feeling stressed (n = 8), feelings of isolation, loneliness and anger (n = 7), feeling low (n = 6), feeling panicky and overthinking. Just under a third of women reported feeling frustrated and worried and scared. The same amount experienced flashbacks or nightmares which related to negative birth experiences, or neonatal illness. One women experienced intrusive thoughts about killing herself.

[insert Table 1 about here]

In addition to the symptoms reported in table 1, the main themes that emerged from the analysis were: (1) not identifying with postnatal depression; (2) the need to normalise support seeking; (3) the need for support irrespective of diagnosis; (4) the importance of timing; and (5) that a questionnaire is not sufficient.

#### Not identifying with postnatal depression

Twelve of the seventeen women in the sample found themselves bereft of information, advice and support about types of distress other than depression. Thus women largely judged their own distress against descriptions of depression. Awareness of others with depression and reading information about depression led many mothers to decide that they were experiencing a different kind of distress that either they could not access information about, or that was not recognised:

*'I didn't really identify with a lot of the um postnatal depression symptoms. And then I really did not feel like I fitted the box. You know I definitely had the baby blues, they didn't completely go away, but I don't think I've got postnatal depression, but I am finding things difficult.'* (P6)

*'Everything was postnatal depression, you know, do you look after yourself? Have you stopped looking after yourself? And it's like, "no, but I hate my friends who have had babies".'* (P8)

Additionally, there was a perception that health professionals were focussed on postnatal depression and once it had been ruled out there was no further investigation. Acknowledgment by health professionals of different types of postnatal distress was necessary but sometimes lacking:

*'It's almost like once you've said "No I don't" [feel depressed], then that's it, I've ticked that box, she's not depressed she's not going to go home and throw herself off the roof or anything so that's that sorted.'* (P4)

Health professionals would sometime suggest to women that they were depressed even when it did not fit the symptoms women described. This was perceived as being a way of avoiding exploration of women's complex feelings. At an appointment to talk about a difficult birthing experience, one mother felt that exploration of complex feelings was avoided by the midwife:

*'It's just very easy to sort of simplify it for someone else, say 'Oh you're depressed, now you need to deal with it, you need to get some counselling and then it'll be fixed.' (P13)*

Having filled out the Edinburgh Postnatal Depression Scale (EPDS) [16], one mother felt that her negative result for postnatal depression left further distress unidentified:

*'I ticked it all honestly and it came out as "no I'm not depressed", but I still at that time had really strong feelings of... about... after the birth.' (P13)*

### Need to normalise support seeking

Women were keen to promote the message that emotional difficulties are common in the postnatal period, and that help-seeking is a normal and positive action. It was felt that potential postnatal difficulties needed to be discussed but were not::

*'Making more of an issue that it is actually all right to ask for help, and making people more aware that actually everyone gets a problem at some [point]... because sometimes you feel like you're the only one.' (P5)*

*'There does need to be more acknowledgement that finding things difficult and stuff is common.' (P9)*

*'I was never offered postnatal um groups, [I] had antenatal care, groups and stuff but I didn't have any postnatal groups which possibly would have been more helpful.' (P14)*

Once a need for support had been identified, women were not clear how best to access help. Going to the GP could be considered *'a bit serious, somehow like your last resort' (P13)* whilst *'the midwives are so busy... I didn't feel like I could really pick up the phone and ask for help' (P11)*. It was felt that a more proactive stance needed to be taken by relevant groups / healthcare professionals in reaching out to mothers.

Moreover, women reported a fear of stigma related to mental illness. When considering anti-depressant treatment, one participant felt that if she took them *'then [I] would be depressed, that kind*

*of puts it there doesn't it? Which I'd rather avoid I think.'* (P17). More generally, it was felt that it would be useful to increase awareness of distress affecting most women, and thus reduce stigma.

Stigma was also related to support-seeking. Feelings of shame or an acknowledgement of weakness were reported if women had to facilitate accessing help. If support was '*widely and openly available there's no sort of, you know, stigma about it really.*' (P10)

#### Need for support irrespective of diagnosis

Whether women had been diagnosed with a postnatal mood disorder or not, they felt that the impact on their daily functioning and relationship with their infant meant they warranted support. This did not have to be formal support, but time talking with a health visitor or midwife who was visiting for another reason. Women reported that if depression had been discounted as the form of distress, sources of support were unclear or lacking:

*'You're not wanting great things from [the health visitors and midwives], maybe just you know a bit of a chat or for someone to be more aware. You know even the health visitor said, that the main thing is she's here now and we can move on.'* (P4)

*'My health visitor sort of gave me a leaflet about this postnatal depression group saying that it was going to be a CBT type thing and um saying "You know probably it's not for you" because I didn't really classify myself... in that category.'* (P7)

It was generally felt that if a diagnosis of postnatal depression was given, support was available. However, if the threshold for diagnosis was not met, or mothers were not proactive in seeking support, available sources of support were not easily accessible:

*'I didn't think that the care was there easily. I mean there's a lot of care there if you ask for it, but it isn't easily accessible.'* (P12)

#### Importance of timing

The timing of support was considered crucial, particularly for women who experienced acute distress, and who felt that they needed immediate help: *'I needed [support] there, I needed it when she was two or three weeks old and there was nothing.'* (P12)

Women wanted support whether diagnosed or not, but accepted that being assessed for distress was necessary. It was difficult for mothers to establish when would be the optimal time to be assessed for distress or to discuss their feelings. Experiences of filling out the Edinburgh Postnatal Depression Scale came too early for some, who filled it in whilst still under the care of the midwife: *'they do it earlier on when things are pretty easy I would say. I think maybe it could be done a bit further down the line.'* (P5) and too late for others:

*'By the time they did [the EPDS] I was feeling much better anyway because I think that was on her 3 month check. So maybe I would have benefitted had they asked me sooner perhaps.'* (P2)

#### A questionnaire is not sufficient

Most women had experienced filling out a questionnaire (likely to be the EPDS based on its wide usage in the UK) to assess for postnatal depression. Women who found it a useful experience did so because they felt it clarified their symptoms: *'it did highlight...that it is more of an anxiety issue than a depression issue,'* (P17) or it led to some action being taken: *'[health visitor] contacted the community nurse straight away and then I saw her within a couple of weeks.'* (P1). For some, the simplicity of assessment was experienced as *'just a bit unsatisfactory, a bit impersonal'* (P7), *'a little bit embarrassing'* (P12), *'a complete waste of time, but also worse than that, misleading'* (P13) and *'a bit silly because you can say anything'* (P15). It was felt that *'an honest respectful chat'* (P13) would elicit more about women's feelings than the questionnaire which could be interpreted as *'[health visitors] ticking the box of having checked up on you'* (P7).

Whether women were positive, negative or indifferent about the questionnaire approach, it was felt that a questionnaire alone is not sufficient to identify distress. The relationship with the healthcare provider who administered the questionnaire was vital in facilitating honest disclosure:

*'It was actually being spoken to which picked up the problem, not necessarily the questionnaire. I think the questionnaire by its own I don't think would pick up how I was feeling.'* (P9)

## DISCUSSION

This study presents an in-depth exploration of women's feelings of postnatal distress, the symptoms they experienced (in Table 1) and their experiences of assessment and support. Results show that women in this sample often did not identify with the descriptions of postnatal depression and instead described a broad range of symptoms found in various disorders including anxiety, depression and posttraumatic stress. This non-identification left many women feeling alienated and discounted by healthcare professionals, whom women perceived as being focussed on postnatal depression.

Subsequently women only experienced being assessed for or asked about postnatal depression.

Women felt that more should be done to prepare women and support them in the early stages of the postnatal period, regardless of whether they had a diagnosis of postnatal depression or not.

The range of symptoms reported indicates that depression was not the most common emotional difficulty encountered in this sample. However, disorders and symptoms of psychological distress (other than depression) in the postnatal period are not mentioned in the DSM-V [8]. This absence may inadvertently silence discussion of other types of distress with healthcare professionals by promoting the idea that they do not exist. Previous research has suggested that the concept of postnatal depression may limit our understanding of a broader postnatal distress and that indicators of negative mood, such as anxiety and stress are required [17, 18]. The most common symptoms reported by women in this sample were tearfulness and anxiety. Feeling low was only reported by six women (35% of the sample). Whilst the qualitative design means we cannot establish the frequency with which women experience different symptoms this is suggestive and warrants further quantitative research.

This research has a number of implications for postnatal care and assessment. In particular, the type of assessment tool used, the timing of assessment and the nature of subsequent support provided. Women in this study who were assessed for postnatal distress were done so with the Edinburgh Postnatal Depression Scale, which is the most widely used assessment instrument for postnatal depression [19]. Studies show the EPDS to be simple, reliable and acceptable to women [20], but acceptability will be dependent on the timing and method of administration of the questionnaire. Of the symptoms most mentioned by women in this study, some are covered by individual items on the EPDS (e.g. feeling

tearful, anxious, panicky, worried and scared). Although the EPDS was not designed to detect anxiety, subsequent research suggests three items can be used as an anxiety subscale [21, 22]. However, this is not effective at identifying all women with anxiety [23]. In addition, many symptoms that women described in this study are not included in the EPDS. Although no assessment tool is going to include every symptom felt by every distressed mother, the absence of items relating to feeling stressed, angry and frustrated particularly warrants attention. It is notable that when developing the EPDS, Cox et al. [16] included a subscale measuring 'irritability' but subsequently deleted it from the final version as it did not measure depression [24]. Similarly, feeling stressed or overwhelmed is not captured by the EPDS and has been linked to postnatal depressive symptoms [25]. Furthermore, research points to chronic stress as a prominent risk factor in developing postnatal depression [26].

This presence of symptoms relating to psychological problems other than depression suggests a number of possibilities for assessment. First, if an assessment questionnaire is to be used, it may be beneficial to include items about birth trauma, anxiety, anger/irritability and depression. However, incorporating aspects of multiple disorders relating to the mother and child relationship may require a long measure which may not be feasible to administer in practice. Focusing on one screening tool being used at a single point in time may even hinder acquiring appropriate care and support for some women; rather, multiple opportunities for women to discuss their emotions are necessary [27]. The Healthy Child Programme [28], currently being instated in the UK proposes that health visitors have more ante- and postnatal contacts with women, which may facilitate better identification of multiple symptoms and risk factors. However, assessment of maternal mental health in the Healthy Child programme still only recommends asking questions to identify postnatal depression [28]. A different approach could be to ask women a small number of questions, an approach that has shown similar characteristics to other case-finding approaches whilst being less time-consuming [23, 29]. For example, Matthey et al. [23] proposed using a generic mood measure ("In the last 2 weeks have you felt very stressed, anxious or unhappy, or found it difficult to cope, for some of the time?" plus a follow up question for those answering positively) but this has only been tested in antenatal samples. Studies testing other case-finding approaches in the postnatal period are necessary.

There are also a number of implications for timing of assessment. Firstly, the most appropriate time to identify distress must be considered. In this sample all but two women felt distressed within the first six postnatal weeks, and 13 felt distressed at birth. A recent systematic review [30] based on diagnostic interviews, concluded that of the 19.2% of women who experienced major or minor depression in the first three postnatal months, most episodes began after birth. In the present sample, many women also reported distress related to the birth experience, indicating that assessment closer to the time of birth may be helpful. Secondly, assessment needs to fit with timings of interactions with healthcare professionals. The current model of postnatal care [28] involves repeated visits from healthcare professionals in the early days, a health check at 6-8 weeks and immunisations for the baby at 3-4 months providing times for assessment and monitoring of women who may be distressed resulting from the birth or at risk of becoming distressed in other ways.

Proactive support from healthcare professionals and other involved groups is particularly important given the difficulty women had with seeking support. Support-seeking is seen as showing inadequacy, an inability to cope with competing demands of caring for a baby, domestic work, caring for others and often a career. This fits with research showing the pressure women feel to fit the ideal of the perfect woman who can cope and does not need help [31]. In line with previous research, our findings highlight the need for ongoing relationships with caregivers and different models of postnatal care.[32] For example, the involvement of psychologically aware health visitors who could provide simple psychological interventions as required has been shown to be beneficial [32]. Women in this sample wanted both the opportunity to talk about their distress in-depth with a non-judgemental empathic person who could reassure them, and peer support from other women with children [33, 34].

### Limitations

Although qualitative studies can enrich our understanding of women's experiences of postnatal distress, the results cannot necessarily be generalised. Women in this sample were predominantly cohabitating and Caucasian so it is important to see whether similar results are found in other socio-demographic groups, and according to parity and time since birth. Women who had caesarean births were over-represented, and it is possible that these women experienced more symptoms of birth trauma although research suggests subjective birth experience is more important than birth type [35].

## Conclusion

This study provides an in-depth exploration of women's feelings of postnatal distress, the symptoms they experienced and their experiences of assessment and professional support. Issues of assessment for multiple types of distress in postnatal women have been raised. Identification and recognition of symptoms and disorders beyond postnatal depression needs to be improved, through evaluating different approaches to assessment and their acceptability to women. Awareness of multiple types of distress needs to be raised both for women experiencing such distress and for healthcare professionals, to enable them to support mothers. Incorporating a holistic approach focussing on the birth, the mother and her relationships into recent initiatives such as the Healthy Child Programme could be timely and beneficial.

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## DECLARATION OF INTEREST

The authors report no conflict of interest.

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Current knowledge on the subject:

- Anxiety and adjustment disorders in the postnatal period may be as prevalent as postnatal depression
- Screening and assessment of postnatal mental health largely focuses on postnatal depression

What this study adds:

- We provide an in-depth exploration of women's feelings of postnatal distress beyond symptoms of depression
- We consider assessment of multiple types of distress in postnatal women needs to be improved through evaluating different approaches to assessment and their acceptability to women

Table 1. Accounts of symptoms (and number of sample of 17 women endorsing each symptom)

Symptom	Quote	N (%)
<b>Tearful</b>		14 (82%)
	I was just crying all of the time, maybe ten times a day. (P1)	
	I didn't feel depressed, I felt sad. Yeah, well I've never been depressed so I don't know whether I actually felt depressed but I did feel really sad and tearful more than, like, low I think. (P2)	
	I've cried at her [mother] more than I ever...especially over the breastfeeding thing, I shed more tears over that than I've ever done over anything before. (P4)	
	There were times when I just went to bed and just cried and cried and cried you know 'cause I just couldn't, I felt like I just couldn't cope, you know, and like I didn't know what I was doing. (P16)	
<b>Anxious</b>		11 (65%)
	Lots of it is just kind of non-specific fear I think of what might happen which I've realised isn't even really logical. (P6)	
	I was having anxiety about sort of illness of me, and illness for [baby] and I'd constantly check him when he was asleep to check he was still alive, and it was those, that's how the anxieties came out. (P9)	
	It was very much an anxiety based thing about um my new life. (P12)	
	I started feeling, during the day and into the evenings kind of sick with worry, I'd wake up in the morning and I'd just start crying...(P17)	
<b>Stressed</b>		8 (47%)
	There are just certain points in the day when I've had enough. Um you know a few times like, "She won't feed!" and just bursting into tears. (P5)	
	The other night I did just sort of hand her to [partner] and say "Can you please just take her!" you know you do get to the end of your tether a bit.(P11)	
	I was just wound up, I was tense, frustrated, um these two would sort of... I mean she was only a few months old um and I just felt like everything was slipping through my fingers. (P14)	
	I was exhausted, I'd had the caesarean, I was still a bit ill um and I remember talking to a health visitor then saying "You know I'm finding everything that's happened really stressful, you know, it's been a massive amount of stress." (P15)	
	I'd had in my mind he'd get to six months and start to sleep through the night and actually he started waking up earlier...so that I found quite stressful, when you think it's about to start getting easier it actually started getting harder. (P17)	
<b>Isolated and lonely</b>		7 (41%)
	I just felt really isolated you know that everybody else's life seemed trundling along and I was just in here in the dark in my pyjamas feeding her. (P4)	
	Having gone back to work, because there is nobody, there is no other mothers with young children, so you feel alone and isolated. (P9)	
	...All the visitors go away and everyone goes back to work and you know then two, three weeks later it's just you and this baby, it's very very scary. (P10)	
	I want a bit more understanding. A bit more understanding from other people who are close to me...to be around or to meet more like-minded people and I mean this is, in this town there's not, there's nothing- that I know about anyway. (P13)	
	I had four walls you know, and the most I could do perhaps was get out at the weekend when my husband was at home. (P14)	

## Angry

7 (41%)

But it's as if, in the heat of the moment, uh, I go further than I'd want to go and there's just so much rage and I've run into the kitchen and given the bin such a hard kick...(P6)

I was quite actually, really angry, I mean things, um, it sounds awful, I felt um that my baby was to blame slightly...(P8)

I'm getting really cross when really I shouldn't, I should just let things go. ...Even though it's nine months ago, I still feel very angry and probably always will about [the birth]. (P11)

I just had rage coursing through my veins, absolute sheer rage and I couldn't, I couldn't rationalise it...(P14)

...So this kind of feeling really angry about things that... were, I can't really do anything about, they've never really made me that angry before, it was really weird. (P17)

## Overthinking

6 (35%)

...Maybe I got a bit paranoid - overthinking - you know, oh my god, will it have an effect on [baby] for the rest of her life? (P2)

I'm trying to think back when I first started thinking about it a lot. I think, [the birth] was constantly on my brain, I constantly at least thought about what happened about 5 times a day. (P8)

'Cause I was "Oh my life's going to be like this in six months," or "What's my life.." you know and they were like "You don't need to think about that, you need to get through today." (P12)

Int: So you were always looking for a reason?

P 14: Yeah yeah and analysing it and reanalysing it.

## Feeling low

6 (35%)

...That kind of constant low feeling, that things would never change or never be back to normal or I'd never know how to quite be her mum properly...(P4)

It's not just a normal low, it's a "I hate the world" low. (P8)

...It would be very very low and like actually everything is terrible and this happened and that means that'll happen in two weeks' time and the low points where everything would be twenty times worse than realistically what it was...(P10)

I'd wake up every morning and dread getting up, that just awful, I just wanna stay in bed, I can't deal with [the children] they're two people that want everything from me all the time and I just, I can't give it. (P14)

I just got really low just thinking "God, we're just never going to get out of [the hospital]" you know and I was just starting to feel like I couldn't cope with it anymore, because it was such a kind of ...toll on me. (P16)

## Panicky

6 (35%)

The only time I would cry is if he was, if he'd driven me to a panic, basically. (P6)

I sit here and I have moments when I get quite panicky about dying, it's quite strange. (P8)

It's just like the world suddenly closed in on me and I just couldn't be there I couldn't be in that spot anymore. (P9)

I was having panic attacks, um you know lots of palpitations, yeah a lot at night...(P12)

I was in such a panic, in such a... doubting myself, I suppose that is lack of confidence isn't it really but I wouldn't have called it that at the time. (P13)

**Flashbacks/intrusions  
/ nightmares**

5 (29%)

I had a flashback about a week and a half ago and um still have nightmares. I had a nightmare about um I'd killed someone and they were giving me an epidural as the death penalty. (P7)

... We've got a bottle of diet-coke and I know it's 2 litres of coke and I just think that's how much blood I lost, you just start thinking these really random things sometimes. (P8)

... Although she was home, she was fine, I still could just see her in the incubator, you know that I couldn't touch her, she was mine but I couldn't touch her. (P10)

My mind was constantly, you know, had thoughts in it that shouldn't have been there. (P12)

**Frustration**

5 (29%)

They say "Well to me you sound depressed," and I know that I wasn't, it was a mountain of frustration... (P4)

[The GP] needed to see how upset I was and how I wasn't coping and how frustrated I was... (P9)

I'm still left with this, sort of I don't know what to call it, either frustration or sadness. (P13)

... There was no moments of... quiet and calm and I just felt wound up all the time, frustrated. (P14)

**Worried and scared**

5 (29%)

I was just worried, scared. I had physical pain and hurting, physical hurting. And then without experience, you've got no order. (P3)

Worried that just, you know, what was I meant to do with him? How was I meant to look after him? (P10)

... It was frightening, it was really frightening to not feel like me and to be so far away from anything I'd ever felt before. (P12)

I walked away, I left all three of them, I didn't go far, just fifty yards down the road but there was part of me that sort of said "You know, you can just keep walking" and that's frightening, that's really frightening, 'cause this is everything I've ever wanted. (P14)

Worried about the fact that I've been so worried and not feeling myself, so that turns into a bit of a cycle, um how it's going to impact on my sleep so that makes me more tired. (P17)

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## Appendix One: Interview questions

### Symptoms

1. Can you tell me about when you first started to feel bad / not like yourself?
2. Can you describe how you felt?
3. Did you feel bad in one way only, or did you experience different ways of feeling bad?
4. Could you notice any pattern to your symptoms?
5. What kinds of thoughts were you having?
6. Can you remember a time in your life when you have felt similar? If so, can you describe that time?

### Impact of distress

7. How did your difficulties / these feelings impact on different areas of your life?

### Screening

8. What was your experience of being asked about your feelings or being given a questionnaire about them?