

Postnatal depression across countries and cultures: a qualitative study

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Background Postnatal depression seems to be a universal condition with similar rates in different countries. However, anthropologists question the cross-cultural equivalence of depression, particularly at a life stage so influenced by cultural factors.

Aims To develop a qualitative method to explore whether postnatal depression is universally recognised, attributed and described and to enquire into people's perceptions of remedies and services for morbid states of unhappiness within the context of local services.

Method The study took place in 15 centres in 11 countries and drew on three groups of informants: focus groups with new mothers, interviews with fathers and grandmothers, and interviews with health professionals. Textual analysis of these three groups was conducted separately in each centre and emergent themes compared across centres.

Results All centres described morbid unhappiness after childbirth comparable to postnatal depression but not all saw this as an illness remediable by health interventions.

Conclusions Although the findings of this study support the universality of a morbid state of unhappiness following childbirth, they also support concerns about the cross-cultural equivalence of postnatal depression as an illness requiring the intervention of health professionals; this has implications for future research.

Declaration of interest None.

There has been a growing international recognition of postnatal depression as a major public health concern. Perinatal psychiatric disorder is the leading cause of maternal morbidity, and suicide is the leading cause of maternal mortality in the UK and probably also in northern Europe (Confidential Enquiries into Maternal Deaths, 2001). It is associated with serious, long-term consequences for maternal mental health (Kumar & Robson, 1984; Marks *et al*, 1992), with marital problems and the psychological health of the partner (Ballard & Davies, 1996), and with adverse effects on the cognitive and social development of the infant (Murray & Cooper, 2003). However, most research into postnatal depression has been conducted in Western, developed countries (see reviews by Kumar, 1994; O'Hara & Swain, 1996) and has not taken into account the range of different psychosocial experiences likely to be involved in childbirth – for example, differences in rates of lone motherhood, the nature of marriage, family and kinship, and variations in the support new mothers receive in different countries and cultures.

Childbirth is a significant life event, which permanently changes the status and responsibilities of the woman, and, like marriage or entering adolescence, it is usually marked by a sequence of events referred to as a 'rite of passage'. Rituals, prohibitions and proscriptions accompany the transition to motherhood in almost all non-Western societies and provide guidance and social support while the mother adapts to her new role (Cox, 1996). It has also been suggested that they may protect mothers from becoming depressed (Jones & Dougherty, 1982; Seel, 1986). Stern & Kruckman (1983), in a review of the anthropological literature, found 'surprisingly little evidence of the phenomenon identified in Western diagnoses . . . as postnatal depression' and

suggested that the lack of post-partum rituals in Western society might be a cause of postnatal depression. It is a plausible hypothesis that intact post-partum codes of behaviour, high status of motherhood, and social support might protect against postnatal depression. The effectiveness of counselling in treating the condition may be through its re-creation of post-partum 'structure' and the provision of social support which might formerly have been provided by the extended family and public recognition of the new role.

Support for the idea that postnatal depression is a Western phenomenon comes from descriptive accounts of motherhood in Nigeria (Kelly, 1967), China (Pillsbury, 1978), India (Gautam *et al*, 1982), Japan (Shinagawa, 1978) and southern Africa (Chalmers, 1988). However, studies in various European countries, Australia, North America, Chile, Uganda and Nigeria (Cox, 1983; Dennerstein *et al*, 1989; Jadresic *et al*, 1992; Thorpe *et al*, 1992; Aderibigbe *et al*, 1993; Areias *et al*, 1996) show no substantial difference in rates of postnatal depression, whereas studies in other countries, for example Japan, Hong Kong and Malaysia, show lower rates (Kit *et al*, 1997; Lee *et al*, 1998). All these studies used Western concepts of depression and standardised research instruments (albeit translated). Over the past two decades the instrument most frequently used internationally for research into postnatal depression has been the Edinburgh Postnatal Depression Scale (EPDS; Cox *et al*, 1987). However, no study has been conducted across several cultures simultaneously to compare the prevalence, psychosocial origins and consequences of postnatal depression.

Problems with international research into postnatal depression in particular, and depression in general, are further compounded by the concern expressed by many authorities about the universality of the concept of depression. The cross-cultural equivalence of morbid unhappiness as an illness, to be measured and quantified in research (metric equivalence) and requiring intervention and treatment, has been questioned (Kleinman, 1987; Mari *et al*, 1989).

From the outset, the transcultural research project was underpinned by the realisation that without an understanding of the commonly held attitudes, beliefs and customs about pregnancy and childbirth in the different participating nations and cultures, it would not be possible to

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develop and harmonise research instruments for use in all of the centres. Nor would it be possible to make meaningful comparisons across centres and interpret the results. It was also realised that health care systems, personnel and material resources differed widely across the participating centres, as did the pathways to both mental health and maternity care. These factors would not only influence the interpretation of the research findings but also have a major impact on any recommendations for service development. Medical anthropologists, therefore, played an essential part in the original project development team study and their influence was felt in the development and harmonisation of many of the quantitative instruments described in this supplement. However, their influence was particularly prominent in the development of the qualitative component of the study described in this paper.

The aim of this qualitative study, therefore, was to clarify whether or not postnatal depression is a universal experience with common attributions and expression across nations and across cultures, whether it is a universal experience of differing attributions and expression, or whether postnatal depression is a concept confined to the West. In order to avoid the assumptions of cross-cultural equivalence inherent in quantitative research instruments and the questionnaire method, it was felt that qualitative methods were the appropriate way to explore and gain understanding of the attitudes and beliefs of women and those involved in caring for them and making suggestions for the systems of their care. The objective of the first phase of the study was to develop a technique that could reliably be used by researchers of different professional backgrounds, speaking different languages, across nations and across cultures, enquiring into broadly similar areas of experience. The intention was to develop a technique that could be used and analysed locally but could provide meaningful comparisons across centres, nations and cultures. Although the numbers of informants in each centre would of necessity be small, it was felt that combined across centres the number of informants would be large enough to lend strength to findings of commonality as well as difference. This strength would also allow us to generate theories on how best to help women in difficulties at this time, as well as theories on barriers they might face to accessing appropriate help.

It was felt that an approach combining phenomenology and grounded theory was ideally suited for this purpose. The process of enquiry, exploring meaningful connections between phenomena and progressively seeking to discover the irreducible core experience, is essential to the qualitative approach. In this process the informant is the teacher and the interviewer the pupil. The informant's descriptions of the experience are the data. The interviewer guides the informant in broad areas of enquiry but adopts a flexible approach to allow new information and unexpected areas of experience to be described. Grounded theory is a method of theory development based on systematically gathered and analysed data (Glaser & Strauss, 1967). This approach has many advantages, as the data collection and analysis provide well-grounded, rich descriptions of processes in local contexts from the perspective of the people under study. It assists researchers to go beyond their initial conceptions and to generate and revise conceptual frameworks. 'Triangulation' allows the use of different sources of information to corroborate each other.

A further aim of the study was to be better informed about appropriate services to meet the needs of women with postnatal depression. Qualitative research methods are particularly appropriate in identifying dimensions of care and treatment that matter to health care recipients, and those that influence health care decision-making and treatment (Murray, 1998).

Transcultural Study of Postnatal Depression

The aim of the Transcultural Study of Postnatal Depression (TCS-PND) was to develop (or modify), translate and validate research instruments that could be used in future studies of postnatal depression in different countries and cultures. The instruments were chosen to assess key aspects of the maternity experience, namely clinical diagnosis, the psychosocial context of pregnancy and motherhood, maternal attachment style, mother-infant interaction, the child's environment, and health service structure, use and its associated costs. The modified and translated research tools were piloted to test how well they worked in a perinatal setting and in different languages and populations. This qualitative study is part of the TCS-PND.

METHOD

Study sites

Details of the study sites are given by Asten *et al* (2004, this supplement). Fifteen centres in 11 countries took part in this qualitative study: Bordeaux and Paris (France), Dublin (Ireland), Florence (Italy), Gothenburg (Sweden), Iowa City (USA), Kampala (Uganda), Keele, London, Manchester and Nottingham (UK), Kyushu (Japan), Porto (Portugal), Vienna (Austria) and Zurich (Switzerland).

Sample

Three different groups of informants were recruited: new mothers; relatives (grandmothers and fathers); and health professionals. New mothers were recruited through health centres, parental support groups, or nurseries or crèches according to local national custom for health contact at such times, using a non-probabilistic purposive sampling method with pre-defined criteria. Recruitment of relatives was through focus group participants, health centres, or contacts of research team members. Health service professionals were recruited by the local research centre leader. All held responsible positions and were influential in planning or providing local health care services. In two of the UK study sites, Nottingham and one of two groups in Stoke on Trent (Keele), the mother and relative informants also came from an Asian ethnic minority group.

Procedure

The project management team, which included a medical anthropologist (S.N.), developed an 'interview guide' based upon broad areas of enquiry informed by the purposes of the study and previous research. These were differently expressed for lay and professional informants but covered the same broad areas of experience. Care was taken from the outset to avoid assumptions of cross-cultural equivalence and to avoid imposing a medical model on the informants. The informant interviews were piloted in different cultures and countries and in a variety of languages. Over a period of 1 year the interview guide was further refined, meanings and other cross-cultural equivalences were verified, and researchers were assisted in the technique of informant interviewing.

The final interview guide explored the informants' views, understanding and

beliefs about the factors contributing to happiness or unhappiness during pregnancy and after birth; their understanding of mental health problems and their causes at this time; their views on what could be done to help, and suggestions for improving health care. For centres studying ethnic minority groups, there were additional probes for health professional informants about whether they thought mental health problems were more or less common and the reasons for them in that particular group of women (see Appendix).

Each centre conducted the following forms of enquiry:

- (a) focus groups of between four and six women whose babies were aged 5–7 months; groups were to be recruited until there was ‘theoretical saturation’ of emerging themes (in practice each centre conducted four to six focus groups);
- (b) interviews with three fathers and three grandmothers of babies (lay key informants);
- (c) interviews with three clinicians and three health planners or administrators in positions of influence (professional key informants).

Interviews and focus groups were conducted in the native language and informed consent was obtained from all key informants and focus group participants. Ethical committee approval was obtained locally in each study site. Interviews and focus groups were tape-recorded and transcribed, and written notes were kept to supplement verbatim transcripts. When tape-recording was not acceptable notes were taken and the fullest verbatim account written within 24 h of the interview.

Analysis

Within each centre individual informant interview and focus group transcripts were analysed as soon as possible to inform the next interview and focus group. When necessary, repeat interviews were conducted until no new areas of information emerged. Next, in each centre the relative informant interviews, the professional interviews and the focus groups were all analysed separately. The transcripts were subjected to textual analysis in the original language, concept coding was developed and themes extracted. These were reduced to the minimum number of themes that adequately captured all the data. These

themes or categories were given codes or titles, which clearly described the meaning of the theme and could be cross-referenced to the data. Further verification was provided by researchers collaborating and cross-checking with each other the themes and their meanings with the data from which they were derived. Annual workshops, at which representatives of all centres were present, provided further verification and clarification of meaning. These themes were then translated into English together with their titles and illustrative quotes. The translations were further verified and cross-checked with the original transcripts to ensure that the meaning was clear and accurate. The translated themes and illustrative quotes were collated and verified at the coordinating centre in London and tabulated for all centres, separately for the focus groups, the relatives and the professional informants, against the original broad areas of enquiry. They were then further reduced to the minimum number of themes that adequately captured the data across all centres. Final verification by the original sites ensured that the translation and emergent themes accurately reflected the data from each centre. Commonalities and differences were then described.

RESULTS

A detailed account of the findings from each centre and the conflated themes and theories generated from the international comparisons is to be found in the report to the EU Commission Union (EU BIOMED-2 Contract BMH4-98-3591; further details available from the authors on request).

Key findings

There was a commonality in the majority of the emergent themes from new mothers across all centres on the contributors to happiness and unhappiness in pregnancy and the post-partum period. A consistent finding across all centres was that the contributors to happiness and unhappiness were not necessarily the converse of each other. Moreover, the contributors to happiness and unhappiness in pregnancy were not necessarily the same as factors that contributed to happiness and unhappiness following delivery. The majority of the emergent themes were found in every centre. Some themes recurred in more than two centres but were not found in all, while

some centres had distinctive themes that emerged only from that centre.

The emergent themes from the informant interviews with fathers and grandmothers closely matched those from the new mothers themselves. However, in some centres the fathers in particular discussed issues relating to their own feelings as fathers and partners that were not raised in the same centre by the new mothers themselves.

Common themes on the contributors to happiness and unhappiness

Physical and emotional delight at being pregnant, together with a confirmation of the progress of the pregnancy and an awareness of foetal movements, was mentioned throughout all centres as a contributor to happiness in pregnancy. Surprisingly little mention was made of the converse. Only in one centre was ambivalence towards pregnancy mentioned as a source of unhappiness (Sweden), and none of the new mothers mentioned unwanted or unexpected pregnancies as a cause of unhappiness. Only one centre (one of the UK Asian groups) mentioned difficulty in conceiving as a source of unhappiness in pregnancy.

Physical illness and discomfort were mentioned in every centre as a cause of unhappiness in pregnancy. In every centre women commented on nausea and feeling unwell early in pregnancy and, in later pregnancy, discomfort because of their size, tiredness and a lack of sleep. However, the converse was less frequently seen – that is to say, feeling physically well was not often mentioned as a contributor to happiness. Following delivery, although physical discomfort and feeling unwell were mentioned as a contributor to unhappiness in the early days following delivery, the later consistent theme throughout all centres was tiredness and lack of sleep as a contributor to unhappiness. Again, the converse did not emerge as a theme – feeling physically well and having sufficient sleep were not seen as contributors to happiness. The role of health care as a contributor to unhappiness was mentioned in all the European centres and by the UK Asian groups. Unsympathetic maternity staff, with little time to talk, emerged as a theme of a cause of unhappiness in pregnancy. Surprisingly little mention was made of medical interventions

and investigations as a source of unhappiness; indeed, in many European centres the opposite was true. Women expressed the view that scans and other investigations were reassuring and saw the scans as a source of happiness. In most centres women described a physically traumatic delivery as a contributor to unhappiness, as was unsympathetic treatment by health professionals following delivery. However, a satisfactory birth experience and good care by health professionals were not seen as contributing to happiness.

Relationship with the baby

Difficulties with emotional and practical aspects of baby care emerged in all centres (with the exception of the UK Asian group and Uganda) as a source of unhappiness following delivery, but the absence of these problems did not emerge as a cause of happiness. Frequent mention was made in all centres of crying babies, difficulties with feeding and concerns about the health of the baby, but surprisingly no mention was made of negative feelings, of irritation or frustration. Breast-feeding was not mentioned as an issue by the UK Asian group or in Uganda, but was cited as a contributor to unhappiness if causing difficulties, and happiness if going well, in most but not all European centres.

Loneliness, lack of emotional and practical social support, poor relationships with partners, family conflict and tiredness emerged strongly as themes across all centres as causes of unhappiness following delivery. Good social support conversely emerged as the strong uniting theme for the cause of happiness. A theme that also emerged strongly in every centre (except Sweden), to the surprise of the researchers, was the universal theme of the mother-in-law. Her role as a source of unhappiness following delivery was particularly eloquently described by the UK Asian and Japanese women, but was also mentioned in all but one of the European centres. Interestingly, conflict about sexual activity following delivery was mentioned only in Uganda as a source of unhappiness following delivery. Infidelity on the part of the husband was specifically mentioned as a cause of unhappiness following delivery by the UK Asian women and the new mothers in Uganda, and its absence – a faithful husband – mentioned as a cause

of happiness. This view was also expressed by the grandmothers in these countries.

There were notable distinctive themes that were found in only one or two centres. In Uganda lack of food and losing weight was a cause of unhappiness following delivery. The same theme emerged from the older grandmothers of the UK Asian group. Conversely, an adequate supply of food was seen as a source of happiness. In France and the USA weight gain following delivery was a cause of unhappiness, and losing weight and returning to a pre-pregnancy figure was a cause of happiness. Although concerns about work were expressed across all centres, the content of these concerns varied, reflecting the nature of women's work locally. In the UK Asian groups, having too much domestic work within a large extended family was seen as a source of unhappiness; conversely, relief from this work was seen as a source of happiness. In Uganda, heavy physical labour was a source of unhappiness following delivery and assistance with it a source of happiness. In other countries mention was made of conflicts at work (particularly with male colleagues) as a source of unhappiness during pregnancy, and returning to paid employment as being a source of unhappiness for some and happiness for others following delivery. Only in the USA, Austria and France was time away from the baby mentioned as a source of happiness following delivery.

In Uganda delays and difficulties in naming the baby by the partner's family were a cause of unhappiness following delivery. In Japan being unable to return to the mother's house for the delivery and post-partum period was a cause of unhappiness. Among the UK Asian women an inability to engage in the 40-day rest period following delivery was a cause of unhappiness. Another distinctive theme to emerge from the UK Asian study was the all-pervasive influence of consanguineous marriage resulting in close-knit and inter-related communities, giving rise to the issue of gossip and confidentiality.

In some European centres a theme emerged from the fathers of a lack of intimacy between husband and wife, insufficient time to spend together, and interference from relatives (as opposed to the perception of them as supportive) as a cause of unhappiness following delivery. It was unclear whether the fathers were talking about themselves or their partners. Otherwise the themes that emerged from

the relative informant interviews had much in common with those from the new mothers.

Morbid unhappiness (postnatal depression)

Morbid unhappiness was recognised by all centre informants as a common phenomenon following delivery. In most but not all centres, the term 'postnatal depression' was used to describe this condition; it was not so described in Portugal, Switzerland, Uganda or by the UK Asians. The characteristics of the condition were described in all centres and closely approximated to the Western concept of the signs and symptoms of a non-psychotic depressive illness. Most centres saw a lack of social support, family conflict, sleeplessness and problems with the baby as a cause of postnatal depression. Most European centre informants, but not the UK Asians, the Japanese or the Ugandans, mentioned hormones as a cause of postnatal depression.

In keeping with the predominantly psychosocial view of the aetiology of this condition was the view that remedies also lay in the psychosocial domain. Social support from family (and in Europe friends), practical and emotional support from partners and having somebody to talk to were universally expressed as the remedy for postnatal depression. Only in the USA were antidepressants mentioned. There were differences in who should provide this help, no doubt reflecting differences in local resources and pathways to care. In the UK and Ireland the health visitor, or her equivalent, and the midwife and general practitioner were frequently mentioned. In Sweden psychologists were mentioned. In France and Austria a variety of mental health professionals were seen as having an important role, and in some centres, including Japan, the paediatrician and the obstetrician emerged as sources of help. The acceptability of professional psychological therapies also varied among centres and was particularly prominent in France, Austria and the USA. None the less, the strongly uniting emergent theme was that of acceptance, understanding and social support from within family and social networks and of talking therapies if professional help was sought. It was clear that the UK Asians did not regard professional or medical help as appropriate or feel that treatment was indicated.

Themes from the health professionals

There was a remarkable consistency in the themes that emerged from the health professional informant interviews across all centres. Like the lay informants, the health professionals viewed the aetiology of morbid unhappiness following delivery as predominantly psychosocial; however, they alone talked about wider societal and public health issues, maternal youth, ambivalence and child protection issues. The health professionals also differed from the lay informants in their view of morbid unhappiness as representing a spectrum of severity with different causes and solutions. Only the health professionals mentioned puerperal psychosis and the need for mother and baby units and specialist services. Despite their views on the predominantly psychosocial origin of perinatal mental health morbidity, their views on the inadequacies of health care provision and on solutions differed from those of the lay informants. Perhaps not surprisingly, they saw the solutions as more resources and more professionals. In keeping with the lay informants, most health professionals across centres spoke of the increased need for talking therapies. Interestingly, the solutions almost always lay outside their own profession, for example the UK general practitioners saw a need for more counsellors, more training for health visitors and more mental health teams; the obstetricians and paediatricians in Japan and in Italy called for more psychiatric services.

The lack of awareness among health professionals in the UK about Asian women's needs was surprising. Although they believed that there were special and increased problems among this group of women, many saw the extended family issues, perceived as a source of difficulty by the women themselves, as protective. Their views on the solution to these problems were largely restricted to those of adequate translation facilities and the unacceptability of male doctors.

DISCUSSION

The aim of the entire TCS-PND described in this supplement was to develop and harmonise research measures for use in international, cross-cultural research. The qualitative component of the study aimed specifically to develop a novel technique

to explore the attitudes and beliefs of new mothers, their relatives and influential health professionals using common areas of enquiry, differently expressed and separately analysed at each site. Complex and comprehensive systems of verification and referencing were performed, and the themes were reduced to the minimum number that adequately captured the data. These were translated, verified and finally conflated across centres exploring commonalities and differences. Descriptions of local health service organisations and patient journeys to maternity and mental health care enhanced the understanding of the emergent themes and allowed meaningful comparison between centres.

The majority of the emergent themes from new mothers and relatives were found across all centres. All recognised a state of morbid unhappiness following delivery, although by no means all recognised it as an illness with a name – postnatal depression – and a requirement for treatment by health professionals. The description of the characteristics of this state across all centres was comparable to the criteria for a diagnosis of postnatal depressive illness. Informants from all centres viewed the causes of this state of morbid unhappiness as psychosocial with particular emphasis on marital and family relationships, and on emotional and practical support. The new mother and relative informants from all centres viewed the remedies too as lying in the psychosocial domains. Their views on remedies and improvements tended to reflect the organisation of health care in their own country, but for those who felt professional help was appropriate the perceived need was for talking treatments. Within the commonality of themes, there were a number of surprises. One was the mention of the mother-in-law as a cause of unhappiness in all but one centre. Another was the consistent finding that causes of happiness and unhappiness are not necessarily the converse of each other and that different themes for the causation of happiness and unhappiness during pregnancy were found following delivery. Medical, obstetric and health care issues were viewed across the majority of the centres as contributors to unhappiness, but if all went well were not seen as contributors to happiness. Problems in these areas were not seen as contributors to postnatal depression. A number of distinctive themes were found in some centres, importantly in Japan, Uganda and among UK Asians. Health

professionals shared with the lay informants a predominantly psychosocial view of the aetiology of morbid states but saw the remedies as lying within the domain of health care.

This study suggests that morbid unhappiness is recognised universally and appears to have broadly similar attributions and characteristics. However, it is not necessarily recognised by all countries and cultures as an illness remediable by intervention and requiring assistance from health care professionals. This has implications for future cross-cultural research in postnatal depression and adds further weight to existing concerns about the use of Western standardised research instruments in other countries and cultures. It also suggests that new mothers and their relatives view the causes as integral to personal relationships and social networks rather than problems with health care. It suggests that they view the remedies as predominantly personal and psychosocial, and those who acknowledge the need for professional intervention hold the view that they need somebody to talk to. This is at variance with the health professionals' view of a need for improved health care interventions. Finally, the ignorance of some health professionals about the special problems of mothers from ethnic minority groups is a cause for concern and has implications for health care provision.

The limitations of this particular qualitative research study lie in the small numbers of informants in individual centres and the perhaps controversial conflation and comparison across centres after translation. None the less, we feel that the large total number of informants and the finding that the majority of the emergent themes were comparable across centres, together with the distinctive local themes, give strength to the findings of the study.

No health service qualitative study can have a reliable representative sample of participants and none can produce findings that can be generalised to the whole population. Qualitative health service research in general and this study in particular can only generate ideas and questions. The findings can inform the interpretation of the quantitative research data in the TCS-PND and inform future research.

The problem of the cross-cultural validity of quantitative methods and the reliability of qualitative methods suggest that the future of cross-culture perinatal research lies in combining both approaches.

APPENDIX

Focus group and relative key informant interview guide

- What do you think brings happiness to women during pregnancy?
- What do you think brings unhappiness to women during pregnancy?
- What do you think brings happiness to women after childbirth?
- What do you think brings unhappiness to women after childbirth?
- What do you think people (you) know/understand about being emotionally unwell following birth (postnatal depression)?
[Probe for causes] [Probe for local terms]
- When a woman is emotionally unwell during the post-partum period, what do you think can be done to help her?
[Probe for health/help seeking behaviour]
- What suggestions do you have for improving health care for these mental health concerns?

Professional informant interview guide

1. Understanding of mental health issues and psychiatric disorders surrounding childbirth

1.1 Awareness of postnatal depression and other conditions

'Do you think that women may have special mental health or psychological problems after childbirth?'
[Probe if necessary to explore these areas: types of problems, commonality, severity and consequences]

1.2 Views on causes

'What do you think causes this (or these) condition(s)?'
[Probe ideas of causes and awareness of aetiology of each condition mentioned in 1.1]

2. Health service response

2.1 What should be done

'What do you think the response of the health service should be to women who have psychiatric problems following childbirth?'
[Probe about treatments and services for conditions mentioned in 1.1 if necessary to explore these areas]

2.2 Awareness of quality of local services

'Do you think the provision of services locally is adequate or satisfactory for the detection, management and prevention of the problem?'
[Probe on views on quality of services for conditions mentioned in 1.1]
Explore these areas: local services, gaps in local provision, reasons for gaps, what should be done?

3. Special needs of the ethnic group to be studied (omit this theme if not appropriate)

'Do you think that in this particular group of women these problems are more or less common?'

CLINICAL IMPLICATIONS

- New mothers in centres across Europe and elsewhere recognise a state of morbid unhappiness as a common phenomenon following childbirth but not necessarily as an illness.
- Better support from partners and families is widely viewed as the best remedy.
- For those who feel professional help is appropriate, talking therapies are seen as the preferred option.

LIMITATIONS

- The study was restricted to small numbers of informants in individual centres.
- Findings from qualitative research cannot be generalised to the whole population.
- Comparison of themes across centres may be seen as controversial.

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[Probe if necessary to explore these areas: why there are differences, problems women may have with existing services, special requirements, difficulties in meeting the needs of these women]

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