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Self-compassion : What meaning and role does it play in the lives of women who experience anxiety and depression in the perinatal period

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Self-compassion: what meaning and role does it play in the lives of women who experience anxiety and depression in the perinatal period?

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Declaration

I declare that this is my own work and does not contain material that has been accepted for the award of any degree or diploma in any academic or other institution. I further declare that, to the best of my knowledge, this thesis does not contain material previously published or written by others except where due reference is made in the text of the thesis.

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July, 2017.

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1 Abstract

With one in five Australian women suffering from perinatal anxiety and depression, there is a constant need for a greater understanding of the lived experience of motherhood. This research investigated the role and meaning of self-compassion in the lives of women in the perinatal period who experience anxiety, depression and psychological distress. There is a growing body of evidence to support findings that self-compassion is an important source of emotional and psychological well-being, but little evidence on the potential role it plays in the lives of women in the perinatal period. A qualitative approach was chosen to undertake this research and the methodology selected was Interpretative Phenomenological Analysis (IPA). IPA is widely used in health psychology to gain an understanding of individuals' lived experiences in times of developmental change; such as motherhood. Four participants were recruited for in-depth interviews to gain an understanding of their motherhood experience. The results of the study revealed an overarching Super-ordinate theme "Casting Shadows over Motherhood" and identified three major ordinate themes that had a negative impact on the experience of motherhood; emotional suffering, unmet expectations and unhelpful views of self. The themes provide an insight into the lack of self-compassion that was evident in all of the participant's experiences of motherhood and presents an opportunity for further research into prevention and treatment, of perinatal anxiety and depression, through the use of a therapeutic model based on self-compassion.

2 Introduction

In the mental health industry the perinatal period is defined as the period from conception (pregnancy) to one year postpartum (after birth). Perinatal anxiety and depression is the result of psychological, biological and sociological factors occurring during this period and can affect mothers and fathers (Swalm, 2015). For women the adjustment to pregnancy and transition to motherhood, can have a significant impact on their well-being and mental health (Wardrop & Popadiuk, 2013). One in five Australian mothers suffers from a perinatal mental health disorder during the first year of delivery, yet many are not diagnosed or treated (Deloitte, 2012; Swalm, 2015). Perinatal anxiety and depression have adverse consequences not only for the mothers but also their babies and potentially influences the mental health of the next generation (Moreira, Gouveia, Carona, Silva, & Canavarro, 2015). Anxiety and depression in the perinatal period can result in poor attachment and negative parenting which may be associated with problems in the infants temperament, behavioural reactivity, delayed motor and cognitive development and childhood problems such as anxiety, reduced concentration and behavioral problems (Kaitz, Maytal, Devor, Bergman, & Mankuta, 2010; Moreira, Gouveia, Carona, Silva, & Canavarro, 2015; Poobalan, et al., 2007). Apart from potential attachment and developmental issues, mothers suffering from severe mental health disorders are at risk of contemplating or attempting infanticide. As stated in (Swalm, 2015, p.6),

> "..a study examining infanticidal ideas and behaviors in postnatal women, who had been admitted to a psychiatric hospital suffering from a severe mental health illness, showed that nearly half admitted to thoughts of infanticide and a third reported some form of infanticidal behavior such as smothering" .

Women experiencing severe mental health disorders in the perinatal period are also at risk of suicide and maternal suicide has become the leading external cause of death for new mothers. Studies have shown that women who are admitted to hospital who are experiencing severe postpartum depression, which is linked to elevated risks of suicide, are 70 times more likely to die from suicide (Royal College of Psychiatrists, 2002). With the risk of maternal suicide, infanticide and potential attachment issues resulting from women's experiences of mental health disorders in the perinatal period, there is an ongoing and urgent need to find more effective ways to understand, prevent and treat perinatal mental health disorders (Austin, Kildea, & Sullivan, 2007).

There is a growing body of evidence that supports self-compassion as an important source of psychological wellbeing, health and happiness. Self-compassion as defined by Neff (2012), consists of three main components: self-kindness versus self judgement, a sense of common humanity versus isolation, and mindfulness versus over-identification. The combination of these elements interacts to create a self-compassionate frame of mind. Self- kindness is the ability to be understanding, gentle and supportive to oneself rather than treating oneself with judgement or harsh criticism (Neff & Costigan, 2014). Common humanity involves sharing in the understanding that all humans make mistakes and fail, that no-one is perfect. The third component of self-compassion, mindfulness, involves being aware of experience in the present moment with clarity and balance. Mindfulness allows one to neither ignore nor ruminate on negative life experiences or aspects of oneself (Neff, 2012; Neff & Costigan, 2014). Recent research has shown a link between self-compassion and psychological health and wellbeing including; decreased anxiety, depression and stress (MacBeth & Gumley, 2012; Neff & Costigan, 2014; Yarnell & Neff, 2012). Self-compassion has also been linked to less perfectionism, rumination and fear of

failure. Findings in a study by Rockliff, Gilbert, McEwan, Lightman, & Glover (2008), have shown that self-compassion tends to decrease cortisol and increase heart rate variability which offers resilience against negative states of mind.

Research suggests that self-compassionate people report a number of positive psychological strengths such as; optimism, gratitude, positive mood, intellectual flexibility, life satisfaction, emotional intelligence, personal initiative, curiosity and feelings of social connectedness – many of which are the components for a meaningful life (Neff & Costigan, 2014). Studies have found that self-compassion is not just a pre-existing personality trait but it can be acquired through education and training and can result in decreased depression and anxiety and increased well-being and happiness levels (Smeets, Neff, Alberts, & Peters, 2014; Shapira & Mongrain, 2010).

Although there is a substantial body of research focusing on perinatal mental health and self-compassion, there is limited research into the role of self-compassion in the prevention and treatment of perinatal anxiety and depression. Therefore the purpose of this study was to understand the meaning and role of self-compassion through women's lived experiences in the perinatal period. The main aim was to find out if a lack of self-compassion could impact the mental health of mothers in the perinatal period and present an opportunity for further research into prevention and treatment of perinatal anxiety and depression, through a therapeutic model based on self-compassion.

3 Literature Review

3.1 Perinatal Anxiety

Perinatal anxiety often begins during pregnancy and continues after birth. About 14-16% of women present with clinical levels of anxiety during their pregnancy, while 8-10% of women present with clinical levels of anxiety postnatally (after birth). Although diagnostic criteria for perinatal anxiety are not currently defined, the symptoms are similar to those involved in anxiety disorders occurring at other times in life. These can include excessive concern or worry, intrusive thoughts, behaviors and impulses that interfere with daily tasks, panic attacks, feeling irritable, restless or "on edge", having tense muscles, a "tight" chest and/or heart palpitations, sleep difficulties, irrational fears (Health, 2016; Pawluski, Lonstein, & Fleming, 2017).

Although there is a substantial body of research on perinatal depression and related psychological distress, some researchers have implied that anxiety about motherhood and self- criticism account for most perinatal psychological distress (Coates, Ayers, & De Visser, 2014; Wardrop & Popadiuk, 2013). Until recently, there was a lack of understanding and very little discussion regarding perinatal anxiety and the impact it has on the experience of motherhood. Some authors reported rates of Generalised Anxiety Disorder in the postpartum period to be as high as 8.2% (Wenzel, Huagen, Jackson, & Brendle, 2005), and there was evidence of increased symptoms of panic in the postpartum period (Bandelow, et al., 2006). Further research by Yelland, Sutherland and Brown, (2010) revealed 12% of women in an Australian study scored high levels of anxiety at six months postpartum and 8.1% of their sample showed evidence of co-morbid anxiety and depression. The high levels of anxiety and co-morbid anxiety and depression highlights the

need for more understanding into the experience of mothers living with these psychological issues in the perinatal period.

Findings from a recent qualitative study by Wardrop and Popadiuk (2013) into women's experiences with postpartum anxiety have identified high levels of self-criticism and the role of high expectations on self and others to be some of the major causes of psychological distress during the transition to motherhood. Wardop and Popaduik (2013) conducted a qualitative study to gain an understanding of some of the factors that may have contributed to increased anxiety during the perinatal period. The study revealed that high expectations of self, others and societal norms increased the mothers level of anxiety and self-doubt which resulted in an inability to cope and increased psychological distress. Participants in the study also reported disappointment in their expectations of the bonding and attachment experience that contributed to them feeling heightened levels of anxiety. Social comparisons and social norms also contributed to negative views of themselves as mothers and caused feelings of failure, insecurity and inadequacy. All participants in the study reported feeling overwhelmed by the adjustment to motherhood and the burden of responsibility and were unprepared for the uncertainty surrounding the transition. One participant described motherhood as "the most unnatural, joyous journey" (Wardrop & Popadiuk, 2013, p.17). The study concluded there is a need for healthcare professionals to provide improved support to new mothers in the perinantal period and to expand the understanding of perinatal distress through a relational lens into their lived experiences.

3.2 Perinatal Depression

Perinatal depression tends to develop gradually and may last for many months. It may start before or during pregnancy and then continue after childbirth, or it may arise for the first time after the birth. The symptom profile of perinatal depression is similar to depressive disorders experienced at other times in life and can include sad/low mood, feelings of guilt, shame, worthlessness, restlessness and/or agitation, impaired concentration, fear of being alone, lack of enjoyment or interest in usual activities, insomnia or excessive (too much) sleep, nightmares, appetite changes (not eating or over-eating), feeling unmotivated and unable to cope with daily routine, decreased energy and feeling exhausted, withdrawing from social contact, lack of self-care, thoughts about suicide or self-harm (Health, 2016; Pawluski, Lonstein, & Fleming, 2017). If left unrecognised and untreated, it may develop into a chronic condition or come back in a following pregnancy (Health, 2016).

Commonly reported risk factors in the literature for perinatal depression are; being single, being young, low socio-economic status, being anxious, being exposed to major life stressors and having a history of depression (Howell, Mora, & Leventhanl, 2006). There is a growing body of evidence that suggests social and cultural views and beliefs, place unattainable expectations on mothers and promote an unrealistic experience of motherhood (Harwood, McLean, & Durkin, 2007). Hall and Wittkowski (2006) report that women perceive a need to be "good" mothers, to be perfect and fit into socially constructed moulds. As a result they are hesitant to disclose their true feelings of guilt and shame for fear of being deemed unfit for motherhood.

A study by Kauppi, Montgomery, Shaikh and White (2012), on postnatal depression, further supports the view that the reality of motherhood does not match the

perceived expectations of mothers and often results in depression. Women were found to question their worth when their motherhood experience does not match the societal myths of ideal mothering. For women in the study by Kauppi et al. (2012), the experience of the initial stages of motherhood was negatively influenced by fear, guilt, isolation, loss and feelings of being overwhelmed and vulnerable. Many of the women studied felt the need to hide their symptoms and repress their feelings for fear of being judged as unfit or "not good enough" mothers. Postnatal depression was seen to occur as a result of mothers not being able to experience and express their feelings and have them validated and normalised in a supportive, non-judgemental, accepting environment. This research revealed that women who suffer from postnatal depression had not been able to express their sadness, fear, guilt and loss. Many suffered in silence which increased their depressed state of mind and caused them to isolate themselves more.

Loss of identity is a common link to postnatal depression and the study by Kauppi et al. (2012) showed that for many mothers the baby does not bring a sense of completion but can lead to a complicated array of losses (Kauppi, Montgomery, Shaikh, & White, 2012). A new mother may face a sense of loss over her autonomy in accepting the change in role identity from the person she once was, to the mother she has become. Their data revealed that mothers may experience a sense of loss of independence, social identity and physical self, which could result in them becoming self-conscious and self-critical. As a result, levels of self-esteem decreased, feelings of negative self-worth were internalised and the mother's negative experience of motherhood were perpetuated.

A further contributing factor to this process was the issue of lack of self-care. New mothers can become so focused on caring for their babies that they struggle to take care of themselves which can result in physical and emotional exhaustion. Postnatal losses of

autonomy and identity, body image and appearance, sexuality and relationships and the inability to be a perfect parent, have been shown to negatively impact the experience of motherhood and increase the development of postnatal depression. The study findings highlight how social and cultural expectations of the motherhood experience may remain unattainable, and as a result, women's expectations of themselves as mothers may set them up for failure, and often result in postnatal depression (Kauppi, Montgomery, Shaikh, & White, 2012; Hall & Wittkowski, 2006).

3.3 Perinatal Distress

Mothers may experience a number of psychological problems during pregnancy and after birth that cause them emotional distress. Perinatal distress often falls outside of diagnostic categories as it does not meet the criteria for anxiety and/or depression but it can result in anxiety and/or depression, stress and low self-esteem. A lack of recognition of perinatal distress has prompted a number of qualitative studies to be undertaken focusing on the actual lived experiences of motherhood. One such study by Coates, Ayers and De Visser (2014), into women's experiences of postnatal distress, revealed psychological processes of self-blame, guilt, avoidance, distancing and adjustment difficulties which persisted throughout the motherhood experience. Distress experienced between the expectations and reality of pregnancy, birth experiences and breastfeeding was maintained through the psychological processes such as feeling overwhelmed, guilt and shame, avoidance and isolation. Data revealed that distress increased with a lack of support during and after pregnancy and the personal challenges of changing role and identity in existing relationships (Coates, Ayers, & De Visser, 2014).

A study by Lazarus & Rossouw (2015), into mother's expectations of parenthood, revealed that although pregnant women approach the transition to motherhood with

optimistic expectations, their experiences do not always match their expectations often resulting in depression, anxiety, stress and low self-esteem. One of the critical variables highlighted in the study was how a women feels about herself determines her ability to adapt and transition to motherhood. It appeared that when a woman perceives herself as not living up to her own or societal expectations she may begin to doubt if she is a "good enough" mother and may feel fearful of expressing her feelings for fear of being judged. This often results in feelings of inadequacy, self-doubt, and lack of self-worth which in turn result in the mother becoming anxious, depressed and stressed.

Another factor is that the grief and loss experienced by women as they transition to motherhood may not be socially accepted or recognised, which may result in new mothers feeling judged, and invalidated (Lazarus & Rossouw, 2015). This lack of acknowledgement, of the loss mothers experience in the transition to motherhood, can result in suppressed sadness and extreme feelings of guilt and shame, all of which may contribute to depression, anxiety and psychological distress. The study also revealed that, when a mother's expectation of her child and the relationship she will have with it, do not match the reality, the mismatch causes intense psychological distress for her. Often this leads to feelings of failure and self-doubt which have a direct impact on the mother's self-esteem and sense of self-worth. Lazarus and Rossouw (2015) concluded a mother's views of herself and her expectations of motherhood are key factors in predicting psychological distress in the perinatal period, and highlight the need for any negative experiences of motherhood to be accepted and normalised.

3.4 Self-compassion

In order to understand the concept of self-compassion there is a need to define and understand compassion. The standard definition of compassion as cited in Gilbert (2014,

p.19) is “a sensitivity to suffering in self and others with a commitment to try and alleviate and prevent it” (Lama, 1997). In Buddhism compassion is seen as a way to help individuals train their minds in order to improve wellbeing and foster enlightenment. The compassionate view of themselves and others that an individual develops, enables them to cope with difficult emotions and challenges with greater awareness and understanding (Pauley & McPherson, 2010). The value of compassion on psychological and physical health has proliferated research studies over the last 25 years and the construct of compassion has been broken down into three main areas – compassion we experience for others, compassion we experience from others and self-compassion (Gilbert, 2014).

In the last decade self-compassion has become an area of significant interest and research in psychology, as it supports the cultivation of a healthy and caring attitude towards the self, and is an important factor in the development of psychological wellbeing. Gilbert (2014) explains the development of compassion for self and others through an evolutionary model emerging from the attachment and affiliation behavioural systems. According to Gilbert’s social mentalities theory individuals who are raised in safe, secure environments who experience validating relationships with care-givers may be more likely to relate to others and themselves in a compassionate and caring way.

The majority of the burgeoning studies on self-compassion incorporate the conceptual definition of self-compassion proposed by Neff (2003) consisting of three main elements; self-kindness, common humanity and mindfulness. Self-kindness is described as the ability to show kindness to oneself instead of criticism, self-doubt and judgement. Common humanity is the acceptance and understanding of the shared human experience (not unique to self), including acceptance of suffering in the face of failure and the ability to deal with unmet expectations with compassion and understanding. Mindfulness is a way

of acceptance when experiencing painful feelings and thoughts instead of over-identifying with them and being able to hold them in awareness. Mindfulness fosters a flexible thought process that is not influenced by personal views but allows for a non-judgemental acceptance of feelings and mental states (Neff, 2012).

Research consistently suggests that greater self-compassion is an important source of wellbeing and is associated with reduced negative states of mind such as anxiety, depression and stress. A recent study by MacBeth & Gumley (2012), found an association between self-compassion and lower levels of depression. The findings from this research showed evidence for the relationship between self-compassion and mental health, which demonstrated that higher levels of self-compassion were, associated with lower levels of mental health symptoms. The key features of self-compassion highlighted in this study were the lack of self-criticism and self-doubt, which are known to be important predictors in the development of anxiety and depression. This research provides empirical evidence to highlight the importance of self-compassion in developing wellbeing, reducing depression and anxiety, and increasing resilience to stress.

The results from a study undertaken by Neff, Hsieh and Dejitterat (2005), revealed that greater self-compassion is linked to less perfectionism, rumination, and fear of failure. Self-compassion appears to encourage higher levels of resilience and moderates reactions to negative events. The findings from the research showed that individuals with higher levels of self-compassion had more accepting thoughts, less negative emotions and a greater ability to acknowledge responsibility and put their negative experiences into perspective. It was shown that those with self-compassion did not eliminate or ignore negative emotions, but allowed individuals to accept and validate the importance of their emotions, and increased their ability to self-soothe in times of suffering or failure.

Further recent studies by Hollis-Walker and Colosimo (2011) and Smeets, Neff, Alberts, and Peters (2014), suggest that self-compassion is associated with a number of psychological strengths and resilience. Individuals who are more self-compassionate report feeling happier than those who lack self-compassion. Self-compassionate people display higher levels of gratitude, curiosity, emotional intelligence, initiative, optimism, connectedness, intellectual flexibility, and life satisfaction. Smeets et al. (2014), suggest that self-compassion is not just a pre-existing personality trait but assert that it can be acquired through education, training and psychological interventions. The development of self-compassion has a direct impact on psychological wellbeing and is an essential component of living a meaningful life and adapting to transitions in life.

From extensive literature in the mental health industry, it is generally accepted by mental health practitioners, that a mother's psychological state directly affects the child's wellbeing and influences the development of a secure attachment. Maternal anxiety and depression are associated with parenting behaviours that are negative, disengaging, which restrict a mother's ability to be sensitive and supportive. Research by Duncan, Coatesworth and Greenberg (2009), suggests that self-compassion is a pre-requisite for healthy secure attachment and good parenting. Self-compassion is critical to the development of compassion for others and Goldstein has described it as "the heartfelt experience of sharing the pain of another and the wish for alleviation of their suffering" (cited in Hollis-Walker & Colosimo, 2011, p.223). According to Duncan et al. (2009) mothers with self-compassion are more able to perceive their child's distress, separate from their own distress, and respond appropriately. They suggest that the common humanity element of self-compassion (as defined by Neff, 2003), may reduce self judgement and shift self blame in parenting activities, thereby allowing attention to be focused on present parenting tasks. As

mothers with depression tend to ruminate and become absorbed in self blame and criticism, this could prove an essential element in the development of secure attachment. Adding to this, Duncan et al. (2009) propose that the mindfulness element of self-compassion allows a mother to have greater awareness of their child's needs and enables them to respond sensitively.

This is supported by Bogels, Lehtonen, & Restifo (2010) findings that suggest through self-compassion, a parent is able to devote kindness and acceptance towards the self, and extend this approach to their child, especially in negative emotional situations. It is implied that self-compassion is particulary useful for parents who are experiencing mental health disorders such as anxiety and depression. Bogels et al. (2010) conclude that a parent who is able to pay compassionate attention to their child may be able to connect to positive feelings and view themselves and their relationship with their child more positively. Therefore, a parent with self-compassion will be in a more mindful state and may be less likely to over-identify with emotions, will be more accepting of external or situational causes of behavior that are common to all human experience, and be able to tolerate negative emotions through the ability to self-soothe (Bogels, Lehtonen, & Restifo, 2010).

The literature on self-compassion, offers strong evidence that it is a valuable coping resource when people experience major life stressors, negative life events or developmental transitions. Self-compassionate people are less likely to catastrophise negative life experiences, experience anxiety or depression after major life stressors, and avoid challenging tasks for fear of failure. Research suggests that self-compassion can play an important role in the human coping experience.

3.5 Conclusion

This literature review has provided an insight into some of the factors contributing to the potential development of perinatal anxiety and depression as well as offering an appreciation of the potential role that self-compassion may play in facilitating a more positive psychological experience for mothers in the perinatal period. As evidenced by the body of research on self-compassion, self-compassionate people are more likely to cope with major life stressors and transitions with optimism, resilience, emotional intelligence and greater intellectual flexibility. There is no greater transition for a woman than that to motherhood, and a more informed understanding of the role of self-compassion in the lived experience may provide an opportunity for the use of self-compassion in perinatal mental health education programs and therapeutic treatment models.

4 Conceptual Framework and Methodology

In order to address the research question 'What meaning and role does self-compassion play in the lives of women who experience anxiety and depression in the perinatal period?' a qualitative approach was used to investigate and offer insight into the lived perinatal experience. The study investigated the meaning and role of self-compassion through individuals experiences in the perinatal period, which is a task best approached through a naturalistic inquiry using a qualitative method (Punch, 2005). There are a number of qualitative research methodologies that were considered for this research such as; Grounded Theory, Narrative Analysis, Discourse Analysis and Interpretative Phenomenological Analysis (McLeod, 2005; Punch, 2005). The methodological approach chosen, Interpretative Phenomenological Analysis (IPA), was determined by the question which calls for detailed analysis of individuals lived experience in the perinatal period.

IPA was chosen over Grounded Theory as this theory may be more of a sociological approach and draws on larger sample groups and broader conceptual explanations. IPA is more psychological and allows for detailed accounts of personal experiences of a smaller number of participants (Coates, Ayers, & De Visser, 2014; McLeod, 2005). Discourse analysis was ruled out as it focuses more on language in the construction of social reality while IPA allows for cognitions and making sense and meaning from thinking (Coates, Ayers, & De Visser, 2014; McLeod, 2005). Narrative Analysis is concerned with making meaning from narratives and although it was considered, IPA was deemed to be more suitable as it does not limit the meaning making to narratives alone (McLeod, 2005; Smith & Osborn, 2015).

4.1 Strategy and Design

Interpretative Phenomenological Analysis (IPA) focuses on how an individual makes meaning of their experiences and aims to provide descriptive accounts of the phenomenon under investigation (Pietkiewicz & Smith, 2014). IPA is a qualitative approach that draws upon phenomenology, hermeneutics and idiography, and is dedicated to detailed exploration of lived experience and personal meaning (Smith & Osborn, 2015; Smith, Flowers, & Larkin, 2009).

Phenomenology focuses on the way individuals interpret their lived experiences and aims to identify elements or components of phenomena which make them unique. Phenomenologists focus on how people describe, perceive and talk about events and experiences, and withhold personal preconceptions, thereby encouraging the phenomena to speak for themselves (Pietkiewicz & Smith, 2014). By using eidetic reduction, distilling or reducing down, phenomenologists attempt to identify the components that make phenomena unique. Hermeneutics, which originates from the Greek word to interpret or to

make clear, aims to understand the mind-set and language of a person in order to translate their experiences in the world. In other words, when using IPA, researchers attempt to understand what it is like to walk in the shoes of their subjects, and make meaning of their experiences through interpretation and translation (Pietkiewicz & Smith, 2014; Smith & Osborn, 2015). IPA can be described as a dual interpretation process as it firstly requires the participants to describe the meaning of their experience, and then the researcher is required to interpret and make sense of the participants meaning (Smith & Osborn, 2015).

The third theory that IPA draws on is ideography which refers to the detailed examination of individual perspectives in unique circumstances. An idiographic approach requires the researcher to explore every single case before producing any statements about phenomena, thereby focusing on the particular experience of each individual rather than the universal (Wagstaff, et al., 2014; Pietkiewicz & Smith, 2014). Smith et al. (2009) outline IPA's commitment to the particular on two levels; firstly the commitment to depth and detail of analysis and secondly; "IPA is committed to understanding how particular experiential phenomena (an event, process or relationship) have been understood from the perspective of particular people in a particular context."(Smith et al., 2009, p.29). The aim of IPA is to not make generalisations about experiences, but to arrive at claims about individual experience cautiously and after detailed analysis (Smith, Flowers, & Larkin, 2009).

As the intention of this research was to gain an understanding of the role and meaning of self-compassion in perinatal mental health, IPA was selected as a suitable method to allow participants to describe their lived experience of motherhood, and any perinatal mental health issues they have encountered to the researcher. Due to the sensitive nature of psychological distress in the perinatal period, IPA has the advantage of allowing for the

creation of a safe, supportive environment for the participants to openly share their experiences. IPA also provided an opportunity for the researcher to try and understand what an experience is like from a participant's point of view, it encourages lived experiences to speak for themselves and allows phenomena to emerge (Coates, Ayers, & De Visser, 2014; Wagstaff, et al., 2014; Wardrop & Popadiuk, 2013).

4.2 Sampling

IPA aims to give full appreciation of each participant's experience. Data samples are usually small to allow the researcher to give a comprehensive, detailed account of a particular phenomenon. Due to the amount of qualitative data gathered from each participant, and the required detailed interpretation, researchers tend to focus on depth rather than breadth (Pietkiewicz & Smith, 2014; Smith & Osborn, 2015). According to Smith (2015, p.29) the sample size depends on several factors; "the degree of commitment to the case study, level of analysis and reporting, the richness of the individual cases, and the constraints one is operating under". Based on this recommendation, in depth semi-structured interviews were conducted with four participants. Participants were invited to participate in the research through emails sent out by two Women's Health Agencies. The first participant was recruited through a centre that offers support services to new mothers, and the following three participants were recruited through a mother's group network. All participants had experienced anxiety and or depression during pregnancy or after having their babies. Three of the participants had a clinical diagnosis of PNDA. One was self-diagnosed.

Participants were contacted by the researcher via phone and offered information about the study. They were then provided with a Participant Information Letter before agreeing to be interviewed (Appendix I). Prior to the interviews commencing, each participant was

provided with an informed consent form that highlighted the study was voluntary, and their participation could be withdrawn at any time (Appendix II). All participants signed their name on the informed consent form indicating their willingness to participate. Interview dates and times were agreed upon by the participants and the researcher.

4.3 Data Collection

IPA is concerned with detailed personal accounts of lived experiences and phenomena under investigation. It allows for a flexible approach to data collection which can include personal accounts, the use of diaries and focus groups. Most IPA studies, however, have used unstructured or semi-structured, one-on-one in depth interviews with participants to gather data (Smith & Osborn, 2015; McLeod, 2005). In this study, data was collected through in depth semi-structured, one-on-one interviews.

The process of a semi-structured interview allows the researcher and the participant to engage in a conversation in real time, and allows for flexibility of unique and unexpected issues to arise (Pietkiewicz & Smith, 2014; Smith, Flowers, & Larkin, 2009). An interview plan was prepared by the researcher as a guide to the interview and included key areas for discussion in order to facilitate a natural flow of conversation between the participant and the researcher. The semi-structured interview provided the basis for the researcher to enter the psychological and social world of the participant (Coates, Ayers, & De Visser, 2014; Pietkiewicz & Smith, 2014; Smith & Osborn, 2015). The advantages of a semi-structured interview, as defined by Smith & Osborn (2015), include: establishing rapport and empathy with the participant; flexibility in allowing the participant to express themselves freely; freedom to allow the interviewer to probe interesting areas that arise, and the potential to produce rich, meaningful data.

The interviews lasted an hour and were audio recorded and then transcribed, by the researcher in full for analysis (Pietkiewicz & Smith, 2014; Van Parys, Smith, & Rober, 2014; Wardrop & Popadiuk, 2013).

4.4 Research Questions

In conducting this research the researcher sought to capture the experience of motherhood for women who experienced perinatal anxiety and or depression, and gather information related to the elements of self-compassion as defined by Neff (2012). The researcher commenced the interview with the "grand tour" question "Can you tell me about your experience of motherhood?" This allowed the participants to share their lived experience of motherhood in their own words, and provided an opportunity for the researcher to use probing questions during the interview to draw out the factors that influenced their psychological and emotional experience of motherhood.

4.5 Data Analysis

The analysis of data using the IPA framework requires the researcher to immerse themselves into the world of the participants in order to make sense of their experiences. IPA researchers seek to understand and learn from the participants lived experience, and engage in an interpretative process with the transcripts. As stated by Smith & Osborn (2015; p.39);

> A powerful way of thinking what is going on in IPA is in terms of the hermeneutic circle. The hermeneutic circle refers to the way in which interpretation involves a dynamic move between looking at the part and looking at the whole.

In order to analyse the data, the researcher is required to study in detail the transcript of each interview before examining the others – a case by case approach. IPA analysis

requires the researcher to clearly distinguish between what the participant said and the researcher's interpretation of it (Pietkiewicz & Smith, 2014; Wagstaff, et al., 2014).

For purposes of this research, the recommended procedure by Smith and Osborn (2015) was followed. The first transcript was listened to intently, read and re-read. Manual notes were taken detailing any observations, insights and reflections that emerged from the transcript. The notes were then used to identify an initial list of themes that emerged from the interview. In IPA a theme is a way of capturing and making sense of an element of the lived experience of a participant (Pietkiewicz & Smith, 2014; Smith & Osborn, 2015). During this stage the entire transcript was treated as data and a list of chronological themes was produced. From this initial list of themes the researcher looked for clusters or groups of themes that patterned together to help identify a descriptive ordinate label for the clusters. The clusters were rechecked against the transcript to ensure the connections reflected the participants' actual words. Once the clustering of the first transcript was completed a table of themes was produced and the researcher used NVivo software to capture the themes and extract relevant data relating to each theme. (Coates, Ayers, & De Visser, 2014; Pietkiewicz & Smith, 2014; Smith & Osborn, 2015) .

Once the list of ordinate and sub-ordinate themes had been identified and rationalised to exclude themes that did not fit well with the emerging structure or had a weak evidential base, the final table was produced for the first transcript. The remaining transcripts were analysed and interpreted in the same way as the first transcript, and additional themes were identified and added to create a master table of group themes. (Smith & Osborn, 2015; Smith, Flowers, & Larkin, 2009).

The final stage of the analysis required the researcher to translate the themes into a narrative account. As part of the write up analysis, the researcher has presented a full narrative of the study that accurately captures the participants' experiences and delivers a comprehensive account of the research findings. The write-up includes transcript extracts that will support the analytic interpretations presented by the researcher from the emergent themes (Coates, Ayers, & De Visser, 2014; Smith & Osborn, 2015; Van Parys, Smith, & Rober, 2014).

4.6 Summary of IPA

IPA was the preferred qualitative approach for the following reasons: firstly, it was consistent with the aims of the research, which was to examine how people make sense of major life experiences; it is a phenomenological approach focused on exploring personal experience and is not predefined by the researcher; it is interpretative, through the use of a double hermeneutic and requires the researcher to try and make sense of the participant who is trying to make sense of their own experiences (Smith & Osborn, 2015; Smith, Flowers, & Larkin, 2009). When studying women's experiences of transition or distress, Cosgrove (2000) advises an approach should be used that is both phenomenological and social constructionist. IPA meets these requirements. IPA's idiographic nature, which is concerned with the particular, encouraged the participants involved to reveal details about their own personal experiences and allowed the researcher to say something about the participant group (Pietkiewicz & Smith, 2014; Wagstaff, et al., 2014).

IPA is an evidence based approach that has been widely used in the field of psychology and has been used to address a number of research questions in the area of women's health and psychology. These include; a study on women's experiences of post-natal distress by Coates, Ayers, & De Visser (2014), a study by Wardrop & Popadiuk

(2013) on women's experiences with postpartum anxiety, and a study on growing up with a mother with depression by Van Parys, Smith, & Rober (2014).

4.7 Ethical Considerations: Consent and Participants Protection

Prior to collection of data, approval was sought from the University of Notre Dame Research Ethics Committee. In undertaking this research the researcher was also bound by the Code of Ethics of the Australian Counselling Association of which she is a professional member. All participants were informed verbally, and in writing about the study, Issues regarding the rights of individual privacy and confidentiality were addressed prior to interviews taking place. It was clearly outlined that participation was on a voluntary basis. Written consent was obtained from participants with the understanding that they may withdraw from the study at any time. Anonymity was ensured by the use of participant codes instead of the names of the participants; thereby ensuring that all data collected was non-identifiable. Raw data including recordings and transcripts will be stored according to the requirements set out in the Notre Dame University Policy: Research integrity and the code of conduct for research.

5 Data Analysis

The key findings that emerged during the data analysis of this research, indicated that all the mothers interviewed, identified common themes during their motherhood experience. The three main themes identified related to their experiences of emotional suffering, their unmet expectations and their difficulties with unhelpful views of themselves. Emotional suffering was identified as anger, guilt, depression, anxiety, exhaustion, and a general feeling of struggling and making the experience "hard". Unmet expectations were identified as unmet expectations of themselves as mothers, unmet

expectations of partners, family members, friends and medical professionals. Unhelpful views of self, emerged from self-judgement, judgement from others, social comparisons, and a perceived lack of productivity and self-worth. These three overarching themes seemed to cast a shadow over their experience of motherhood, making it a difficult and challenging transition.

5.1 Casting Shadows over Motherhood

Four mothers were interviewed, all of whom had experienced anxiety, and or depression, and maternal stress during the perinatal period. After detailed analysis of each of the transcripts and careful identification of emerging themes, an overarching super-ordinate theme of "Casting Shadows over Motherhood" was identified. This super-ordinate theme is supported by three ordinate themes - Emotional Suffering, Unmet Expectations and Unhelpful Views of Self. The three ordinate themes were broken down further into subordinate themes as highlighted in the table below:

5.2 Table of Themes

"CASTING SHADOWS OVER MOTHERHOOD"

ORDINATE THEME	SUB-ORDINATE THEME	PARTICIPANT STATEMENT
Emotional Suffering		
	Anger and Resentment	*"I became very angry – if I look back on that whole experience I was extremely angry,…."*
	Guilt	*"I think there was a lot of guilt around not getting that diagnosis earlier…"*
	Anxious	*"that anxiety of things going wrong or something was going to happen to someone or to me .."*
	Depressed	*"just being in such a dark place that you can't actually see that you are being silly…"*
	Exhaustion	*"there's another person screaming for you and you are just exhausted…"*

	Struggle	*"I knew that people had challenges but I didn't think it would be that hard…."*
Unmet Expectations		
	Expectations of Motherhood	*"even though its important work it's a big transition going from a professional career …"*
	Expectations of Others	*"it was a battle deciding my own way, listening to everyone else and figuring out what I should do…"*
	Expectations of Self	*"That was a big thing for me you know when you have these expectations of yourself …"*
	Expectations of Support	*"I had doctors basically telling me it was me…you know it's you as a mother not your child …"*
Unhelpful Views of Self		
	Judgement from Others	*"you realise a lot of people around you are judging you as a mother with the decisions that you are making.."*
	Judgement of Self	*"I'm very hard on myself ….second guessing myself all the time…."*
	Lack of Productivity	*"I was under prepared for the lack of productivity you feel on a day to day basis…"*
	Lack of Self Care	*"when I feel rested I am able to do those things but some days I feel so tired that I just can't do those things…."*
	Lack of Self Worth	*"due to this lack of self-worth which is crazy because you are doing the most important job…"*
	Social Comparisons	*"there's so much information on-line, it's about what you should be doing and you are always comparing yourself…."*

5.3 Emotional Suffering

Throughout the interviews all participants expressed emotional suffering in their motherhood experience which included; anger, guilt, resentment, anxiety, exhaustion, depression, and a general feeling of emotional "struggle". The emotional suffering impacted their experiences and made the journey through motherhood difficult and "hard".

Anger and Resentment

The feelings of anger and resentment from one participant came from the feeling of injustice that her husband still had his identity and working career. Accepting her identity loss and sense of purpose, from a career women to a mother, had been difficult. The participant was unprepared for the emotional struggle she would experience becoming a mother.

> *P1… "I became very angry – if I look back on that whole experience I was extremely angry, I was horrible and I cringe about it now but I felt resentful of my husband going to work..."*

Guilt

Guilt was an emotion that was evident in all participants' experiences of motherhood. The guilt manifested in many forms but a common theme was around not enjoying the experience of motherhood as much as they should be or were expected to be. There was also guilt around not accepting that they were struggling, or admitting they were suffering from anxiety or depression sooner, as they believed this impacted their early motherhood experiences negatively.

> *P3 … "but I didn't know that I was suffering from anxiety at that point until it came to a head and a lot of it was the guilt associated with not getting a diagnosis and medication earlier ….."*

> *P2… " I knew exactly how to make everything work and I could be in control of it all but I think there was a lot of guilt around not getting that diagnosis earlier and the fact that it was really hard during that time…."*

P4…. "so I feel guilty all the time if I'm not spending time with the baby and I know it is not valid guilt but I feel like I should be…"

Anxiety

All participants reported feelings of anxiety throughout their experience and one participant reported feelings of anxiety during her pregnancy when she was having issues with sleep.

P4 ….. "In my pregnancy when I wasn't sleeping I would get really anxious and it was linked in together and the more I didn't sleep the more anxious I would get and I really wanted to sleep but my body just wouldn't let me ….so I started becoming anxious about going to sleep and what that night would be like and pacing up and down in the middle of the night."

One of the participants related her anxiety to the fear of someone getting sick either herself or one of her children. Thus, concern centred around the experience of extreme anxiety when one of her children did get sick, left her paralysed and unable to function.

P2 …. " that anxiety of things going wrong and my biggest anxiety issue was someone was going to get sick or something was going to happen to someone or to me – we tried to go away on holiday and my youngest got sick – and we were going away and I was worried about what if he gets really sick what will I do over there and I was really like paralysed by it. I spent the whole weekend paralysed – my husband had to do everything I just couldn't ……"

Another participant explained that the anxiety made her feel out of control and was often triggered by her baby's discomfort and crying.

P3 …. "I tend to have short bursts of anxiety say for example when he is really ratty and I can't get him to sleep and he is crying – then I can feel like I'm not in control here - so it usually just feels like a burst of feeling out of control……"

Depressed

Two of the participants reported feeling more depressed than anxious during their early motherhood experience. One described it as being in a 'dark place' and another said that she had simply 'shut down',

P1…. ".. just being in such a dark place that you can't actually see that you are being silly…..like you know you don't have that insight into it I suppose….so yeah more the depression side of things than the anxiety…."

P4 ….. "I went into a bit of shutdown mode ….."

Exhaustion

All mothers experienced exhaustion that they were unprepared for due to; lack of sleep, broken sleep, or the need to be productive and be able to cope. The feelings of exhaustion often made it difficult for them to be truly attuned to the needs of their babies and when their babies cried their ability to cope diminished.

P1….. "I would wake up in the day and there's another person screaming for you and you are just exhausted – it didn't seem so lovely and rosy….."

Participants reported being under prepared for the lack of sleep and the constant waking during the night.

P1….. "I had never been in a situation where I was truly sleep deprived before so I was very under prepared for that you know the waking….."

One participant reported that the lack of sleep impacted her patience as well as her compassion for herself.

> *P3….. "Yeah so I knew I would be tired but I don't think I had truly thought about what it would do to my patience and my compassion for myself."*

Another participant reported that the sleep deprivation impacted her ability to be productive and achieve simple tasks like getting her children to sleep.

> *P2…. "I think it was so much sleep deprivation and everything felt like it was….like I couldn't achieve anything with them – I couldn't get them to sleep, couldn't get them to eat. I never felt like I was achieving anything…"."*

Participants reported being frustrated that their babies would not sleep and the constant feeling of being tired made it "hard" for them to enjoy the experience and undertake everyday tasks.

> *P2…."……. they had babies that would sleep and nap and I was battling to get a nap out of them and we were still up all night and me and my husband would take shifts at night just so we could get some sleep – so one of us would hold the baby half the night and then the other would take over so I was often up half the night. So I guess I was always frustrated with the first two so it was always hard – it never got easier – it was always so hard to do everything."*
>
> *P3…. "….but I don't think I had a full idea of how incredibly tired you can get …"*
>
> *P4…. " I experienced so much exhaustion from lack of sleep…"*
>
> *"…so tiredness was just…you know it's hard to do life when you are that tired."*

P3… "I just didn't realise how hard things can be when you are so tired – even easy tasks are so much harder when you are tired…""so yeah the sleep thing was one of my biggest challenges…."

One mother sought professional help for her problems with lack of sleep and felt that the advice and support she received was very unhelpful and a perceived over-reaction from the health professional. It discouraged her from seeking help from professionals when she was struggling with any aspect of motherhood.

P4…. "so I went to the Doctor and she said there was nothing she could do for me…so I rang the midwife again and said I need help I don't think you understand and she said "oh we can refer you to the Psychiatrist" and that freaked me out and I said I am not crazy I just haven't slept!!"

Emotional Struggle

There was an overarching theme to the emotional suffering for all participants that implied emotional "struggle" which impacted on the motherhood experiences and made it "hard". Struggles centered on the lack of ability to prioritise tasks and achieve as much as they used to.

P1….. "I always thought I was good at prioritising what was important and what was not important but I think I did not manage that very well when I was struggling…"

P2….. "I guess I could never do anything, it was always hard to get it done– it was always a battle – everything seemed hard – nothing ever flowed and rolled like everyone else seemed to have…"

Although there was some expectation that motherhood would be challenging, it was reported that the challenges were underestimated and were much "harder" to accept. Participants were not prepared for the difficult parts of mothering, such as, the "battle" of trying to get their babies to sleep during the day.

> *P3….. "you know when you have a child that is screaming every time you want to put them down for a nap, you know it was always a battle you know, so that was difficult ……*
>
> *P3 ….. "I don't know if I had a really good notion of what the difficult parts would be like, I don't know that that was really known or if I was prepared for it….."*
>
> *P4….. "I knew that it would be challenging but I didn't know how so ……I knew that people had challenges but I didn't think it would be that hard…."*

5.4 Unmet Expectations

Unrealistic and unmet expectations of self and others was a common theme throughout the motherhood experiences described in this research. The sub-ordinate themes identified in the data were; expectations of motherhood experience, expectations of others, expectations of self, and expectations of support.

Expectations of motherhood experience

Participants stated they were unprepared for the transition, from their identity as career women, to their identity as mothers.

> *P1….. "Even though its important work it's a big transition going from a professional career to being at home all the time …."*

They also reported being unprepared for the fact that not all of the motherhood experience was enjoyable. One mother implied that unlike a regular job, mothers are unable to resign if the tasks are not enjoyable.

> *P1….. "….but I suppose you invest so much in it and if you were in a job you were not enjoying you know….in the real professional world you wouldn't stay there …"*

The expectations of motherhood did not match the reality. All mothers interviewed reported this impacted their motherhood experience.

> *P1….. "So I really thought that I was going to have this wonderful experience of being at home and being engaged with my kids all the time, but I guess professionally that is what I had done, and I gained a lot from that but I wasn't prepared for all the other stuff ….."*

Participants reported it felt like being "thrown in the deep end" and expectations of what it would be like, did not match the reality. They felt there were a lot of challenges they were not prepared for.

> *P2….. "I think I had expectations of what I thought it would be like but I had no idea of what it could be like, how it could really be… I didn't realise that that could really happen and I was really thrown in the deep end when it all went so wrong and it did not happen at all like I thought it was going to be…."*

> *P3… "I guess it was a bit like jumping in the deep end – you know I'm a professor and I've being working hard in my career for a long time and it was a big change but something I really wanted…but there were a lot of challenges…."*

> *P1… "I don't think you know what it is like to be around a new born until you have one."*

One participant described the experience as a "wild ride" and was not prepared for the amount of work involved in becoming a mother.

P4…. "It has been a wild ride ……I knew that people had challenges but I didn't think it would be that hard…."

"I didn't quite know how much stress your body went under when you are pregnant…"

"….but I didn't realise how much work a baby is…and how much work was involved"

"I just didn't know that you wouldn't get five minutes to yourself …"

Expectations of Others

Each participant reported issues with trying to live up to the expectations of others which resulted in them feeling under pressure to enjoy the experience, even in times of discomfort and difficulty.

P1….. "I think there is so much pressure on you to enjoy things but when you are having a hard time it's really difficult…"

"…because everyone says to you enjoy it while it lasts – life won't be better than it is now and that kind of thing …"

Expectations of others made participants feel criticized at times and constantly trying to fit in or meet the expectations of others impacted their way of mothering.

P2…. ".. also first time around I had everyone else and all their advice like your parents saying you are doing things wrong and you are spoiling them, and every choice you do make was kind of really criticised and someone has something to say

about it, and the first time was a battle deciding my own way, listening to everyone else and figuring out what I should do…and trying to figure out juggling what I should do, which expectations I should listen to…"

Apart from expectations from family members, one of the participants felt there were expectations in her workplace on how she should be as a mother and a career person.

P3… "the other thing that is interesting is that I think being in such a gendered workplace and career space, I took on a lot of responsibility, I guess, in my own person, in what I should be and how I should be presenting myself to meet other's expectations…I wondered how much of it is actually me vs is this me just trying to fit in because this is the culture that I am part of….."

Expectations of Self

Participants reported they had high expectations of themselves as mothers and put a lot of unrealistic pressure on themselves to do everything "right". They also expressed they were unprepared for the transition and the uncertainty of motherhood, and the unpredictability of their babies.

P1…. "My expectations of myself were fairly high …"

"….and I would just be thinking about what I haven't done rather than what I actually had done for the day so I put a lot of pressure on myself…"

"It was all very negative – there was a lot of negative, and it's like, you pay attention so much more to the negative things than the positive things, like thinking about what you haven't done…."

"That was a big thing for me you know when you have these expectations of yourself and what you are going to achieve and you know that you are not going to get anything done…"

One participant had an expectation that her experience of motherhood would be different the second time around, but her idea of what it would be like for her was "crushed".

P2.... "I hadn't prepared myself for the expectation that he couldn't be as difficult as my first one, and then when he was I thought I just couldn't do it again. I just couldn't repeat that again…yeah so I had this whole idea of what it was going to be like and it just got crushed I guess….."

Participant 3 identified that expectations she had of herself were caused by the need to "fit in" in the workplace, and also by her need to be a high achiever.

P3…. "Well what I discovered about myself is that I have always tended to fit into that environment and maybe not completely being myself all the time so that I was part of it and accepted in the workplace…"

"…and I know that for me I have always been a high achiever and that is something I brought on myself …I've always been the over achieving professional type of person …"

The expectation that breastfeeding would come naturally and was the only option for her baby, caused one of the participants a lot of distress. In addition it also caused her to let go of some of the high expectations she had set for herself.

P4… "I was very upset that I was breastfeeding and that was the only possibility for me, so I had that pressure…

"…like with the house and stuff, I don't like having mess around or having my laundry on the dining room table I think it is outrageous…but I've had to let some of that go – but everything used to be so perfect – I've just given up on that…

"I had to let go of some of my expectations – it was the only option…."

Expectations of Support

There was an underlying belief from participants that they would get good support from health professionals, family and friends, but all participants reported a lack of support and unmet expectations in this regard.

P1…. "I didn't seek help, I know I could have asked for help but I find the questionnaires quite extreme – you know the EPDS and the DASS…yeah I find them extreme and very easy to lie in them you can just say "I don't feel anxious at all…" so I think if someone had truly sat down and talked to me I think I would have burst into tears and a lot of things would have come out…..instead of this 10 minute appointment that you have and you just fill it out and hand it into the receptionist and just go..."

When support was sought, by participants, from professionals and others, the responses were dismissive and unhelpful. This led to participants feeling discouraged to seek additional support, believing they should be able to cope on their own.

P1….."so when I was worried about something I was pretty much told I don't know what you are worried about …."

P3….. " I think that played a big role in how difficult life was in those early months for me because I had doctors basically telling me it was me…you know it's you as a mother not your child and you are not handling this ……"

P4….." I am not coping I have not slept in a week and I am working and I have to sleep, is there anything you can do for me? I'm going crazy and she didn't offer any support at all. She just said "oh let me look it up", and her words were "ah people who can't sleep during pregnancy are more prone to post-natal depression and problems"…"

Some of the participants felt they were not able to admit to not coping and needed to be 'given permission to say they are not coping'.

P1….."I probably wasn't as honest as I should have been with a lot of people – um in actually saying I was struggling and here's why – I would complain about things but not actually say why I needed help…"

P3….."...someone to go, "here is what I am seeing, am I right?" and then giving me permission to say hands up "I am not coping" …"

For one of the participants there was a lack of family support. She felt the support they did offer was in the form of advice and it was not helpful.

P2…. "That has always been a big issue, we have a lack of family support – we have a massive blended family – both our parents are remarried so we have this massive amount of people around us but no-one we can rely on or anyone who is hands on or wants to be really involved. They're not really there to do anything – pop in parents – they don't actually do much apart from give their two bits of advice……"

Participants felt that friends and other mums were the most supportive people during their pregnancy and after the baby was born.

P3…. "There were one or two friends in particular who were really important just to talk to and to hear you know you are doing alright … "

P4…."… so being able to talk to other pregnant mums because I think not sleeping during pregnancy is quite common, but I thought it was just me and that everyone else was sort of thinking pregnancy was a blessing …"

5.5 Unhelpful Views of Self

Participants reported unhelpful views of self that were identified as: judgement from others, self-judgement, lack of productivity, lack of self-care, lack of self-worth, and social comparison.

Judgement from others

Feeling judged by others was raised by participants as influencing their view of themselves as mothers. This contributed to increased levels of self-doubt.

P1….."Other people – must come from other people – because everyone says to you enjoy it while it lasts – life won't be better than it is now and that kind of thing which is true but you are just so flat out that you don't get the chance to experience things…"

P3… " X was 18mths before I went to sea for the first time and that was only a week, and when she was 3, I went away for a month you know and that's completely unacceptable to most mothers. Even my younger sister said to me "you are going to change your mind you won't last", but she didn't realise that once I was on the ship I couldn't get off you know? You realise a lot of people around you are judging you as a mother, with the decisions that you are making. Some people

are not very accepting of it and some people don't think you are making the right decision, and that makes it difficult…."

Judgement of Self

In addition to the judgement from others impacting the participants' views of themselves as mothers, there was also an element of self-criticism and self-doubt that developed around the fear of not being perceived as a "good enough mother".

P1…. "Well I was worried about putting other people out basically. I guess I was feeling like I wouldn't have been doing what I was supposed to do …."

"….and people kept saying you've just had a baby, you've just had a baby and I would just be thinking about what I haven't done rather than what I actually had done for the day so…yeah, yeah….I put a lot of pressure on myself…"

"…knowing that you are not going to cause any damage by taking a short cut or doing this less than perfect thing…."

P3…. "I think I was pretty judgmental of my abilities …."

P4…. "I'm very hard on myself ….second guessing myself all the time…."

Lack of Productivity

All participants had very productive lives prior to becoming mothers and they all reported being under prepared for the lack of productivity they would achieve on a day to day basis. They did not consider the tasks of motherhood to be productive and were constantly judging themselves for not achieving enough.

P1…. "I was under prepared for the lack of productivity you feel on a day to day basis…"

"…and I keep saying to my husband it's all around productivity,…."

P2… "I think it was so much sleep deprivation and everything felt like it was….like I couldn't achieve anything with them – I couldn't get them to sleep, couldn't get them to eat. I never felt like I was achieving anything…. I guess I could never do anything, it was always hard to get it done– it was always a battle – everything seemed hard – nothing ever flowed and rolled like everyone else seemed to have…"

Lack of Self Care

Participants reported a general lack of self-care and, on reflection, realized that self-care and kindness towards themselves would have made their motherhood experiences more enjoyable.

P1…. "Oh and a bit of self-love and time for myself and a bit of giving myself permission to do something for myself, like I don't have to be there for everyone 24hours 7 days a week . People can survive if I go and take 2 hours a week to drink a coffee in peace or go for a walk or something….."

Participants identified that exercise had helped them overcome stress in the past, but they found being a mother was such a busy time, they did not have enough time to even go for a walk.

P1…."Well I think in the past if I have been stressed or whatever, I know that getting out and moving has helped me, and also it's about what it represents just being compassionate and kind to myself, and not trying to do it all. Also realising that I am doing a good job and, if I can give back to myself, I will be a bit more available for everyone else."

P3…. "I guess these are some of the things that I find that I miss in the first few couple of months with your baby as it is just such a busy time, and you don't get to escape in the evenings and things, but you know throughout my pregnancy and prior to that you know going on my weekly walks with a friend you know, for me that is just such a release…"

P4…. " I feel when I feel rested I am able to do those things but some days I feel so tired that I just can't do those things…."

Lack of Self-worth

Lack of self-worth as a result of judgement from others and self-judgement, led to participants trying to meet expectations and not embrace their own unique experience of motherhood.

P1…. "due to this lack of self-worth which is crazy because you are doing the most important job but yeah just being in such a dark place that you can't actually see that you are being silly….."

P3…. "…and that was for me to be myself and it is something I think about quite a bit because I guess these things happen for people really early on and I guess I started changing myself to fit in when I was much younger …"

Social Comparisons

The participants mentioned comparisons to their own mothers, sisters, and friends, who they believed managed the tasks and responsibilities of motherhood better than they could. Such comparisons resulted in feelings of failure and self-doubt.

P1…. "There's so much information on-line, and so it's about what you should be doing and you are always comparing yourself…."

Social comparisons on social media, the internet, and support groups, such as mothers groups, were reported as being unhelpful, and increased pressure on what they felt the motherhood experience should be like, versus the reality of what they were actually experiencing.

P3… "… mothers group can kind of be dangerous for that ….and the internet can be dangerous for that too…"

"..you know like sometimes it was just useful to know that other people were going through the same kind of thing…but then there were other things where you were trying to look for advice and that can be difficult…because then you can get very conflicting advice…"

".. potentially comparing yourself to these dream kids that other people have is just not helpful…"

"…to compare yourself and always comparing your baby and yourself to people that are very different to you…"

P4….."Yeah I compare myself to everyone……so I found that everyone I met has a baby that sleeps – they all say they are pretty lucky their baby sleeps and I'm still looking for that one that says this is horrendous and my baby doesn't sleep….I look on the internet far too much and diagnose things that I don't need to be diagnosing, especially around breastfeeding and stuff…"

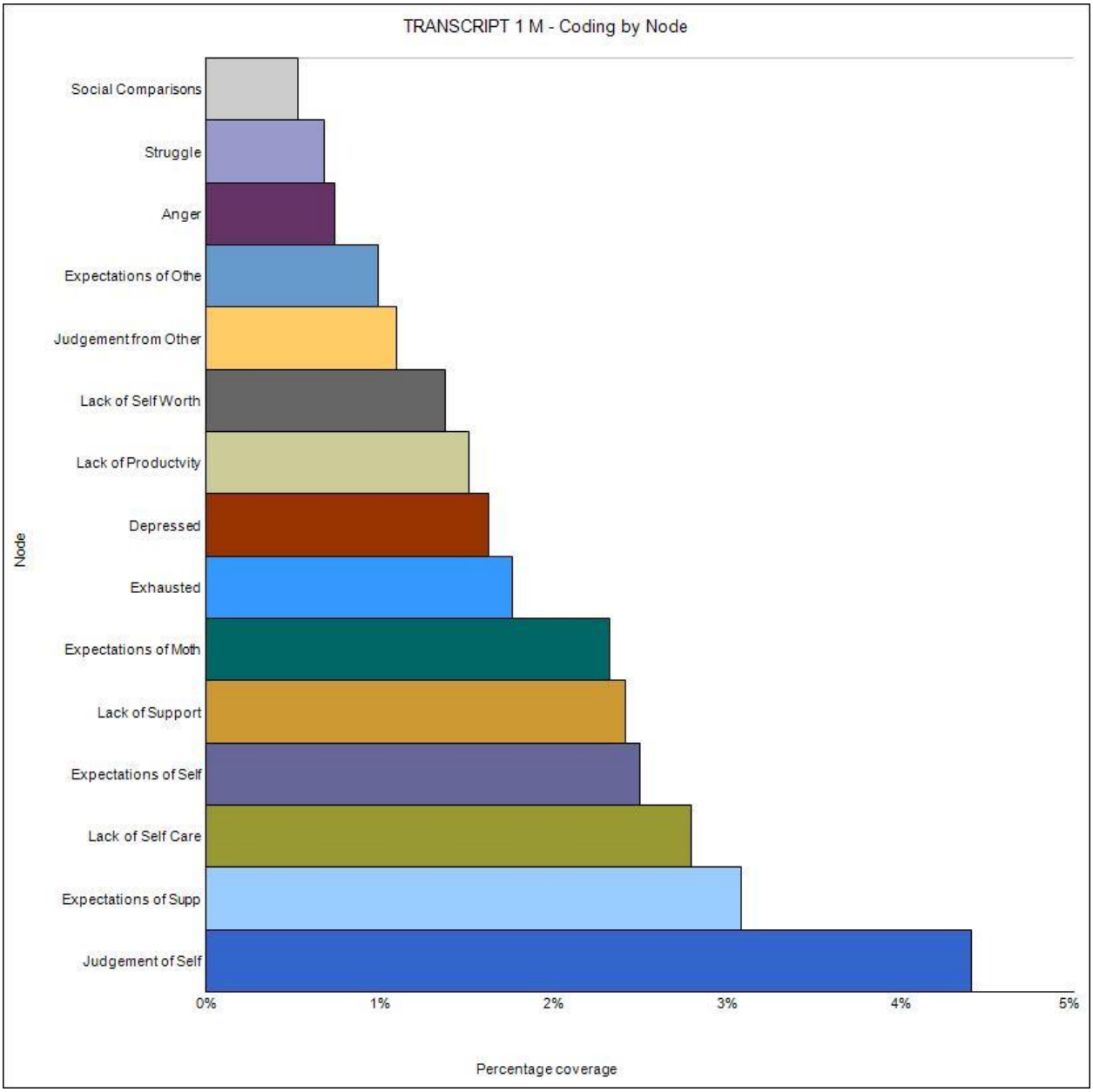
5.6 Summary of Emerging Themes from Interviews

Below is a graphical summary of the sub-ordinate themes that emerged from the data. It indicates the occurrence of each sub-ordinate theme identified by each participant. The sub-ordinate themes identified made up the three ordinate themes; Emotional Suffering, Unmet Expectations and Unhelpful Views of Self.

The graphs below illustrate which themes are more often mentioned by each participant and this data was extracted from the transcripts using NVivo.

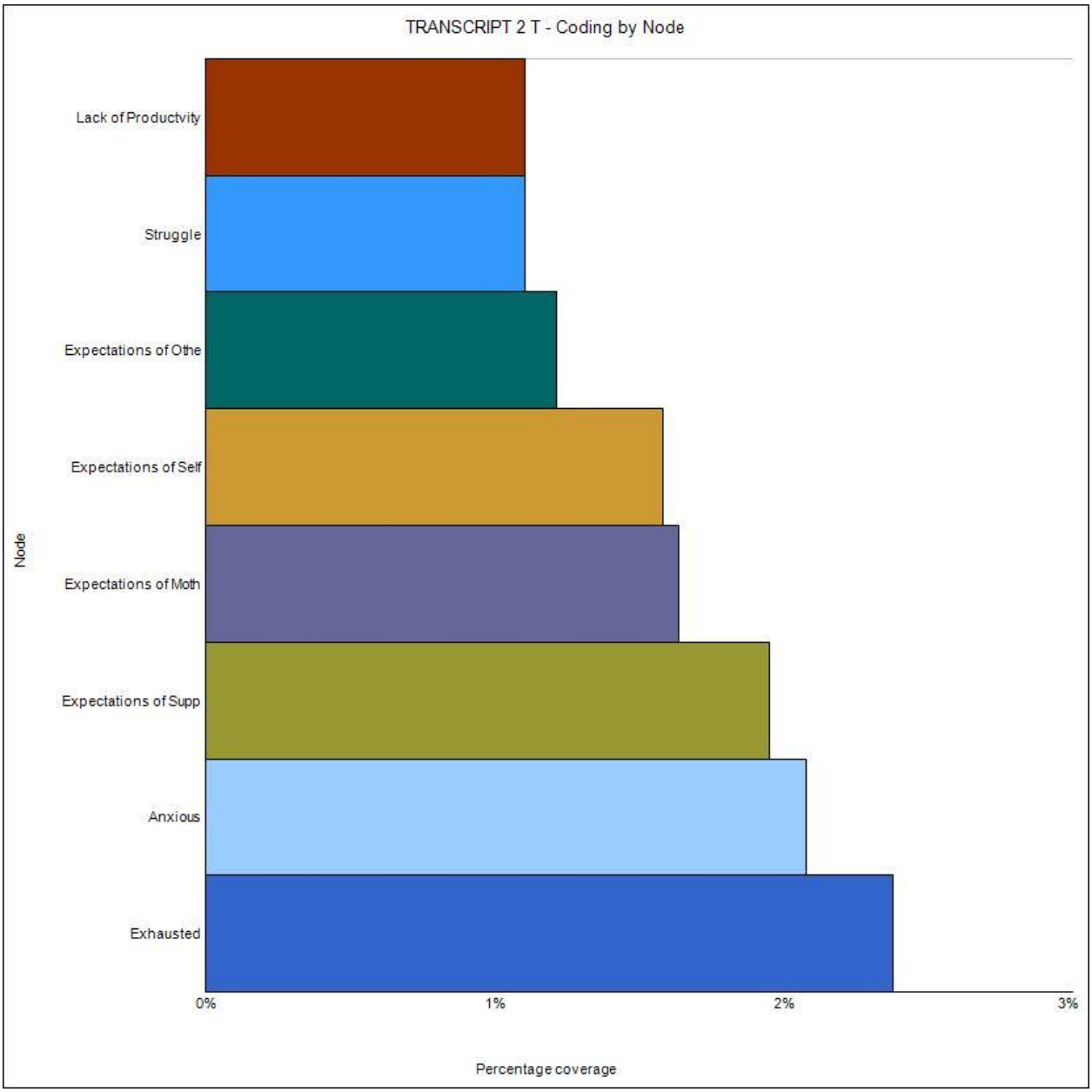
Major Themes Identified for Participant 1

Self-judgement, expectations of support, lack of self-care, expectations of self, lack of support and expectations of motherhood.



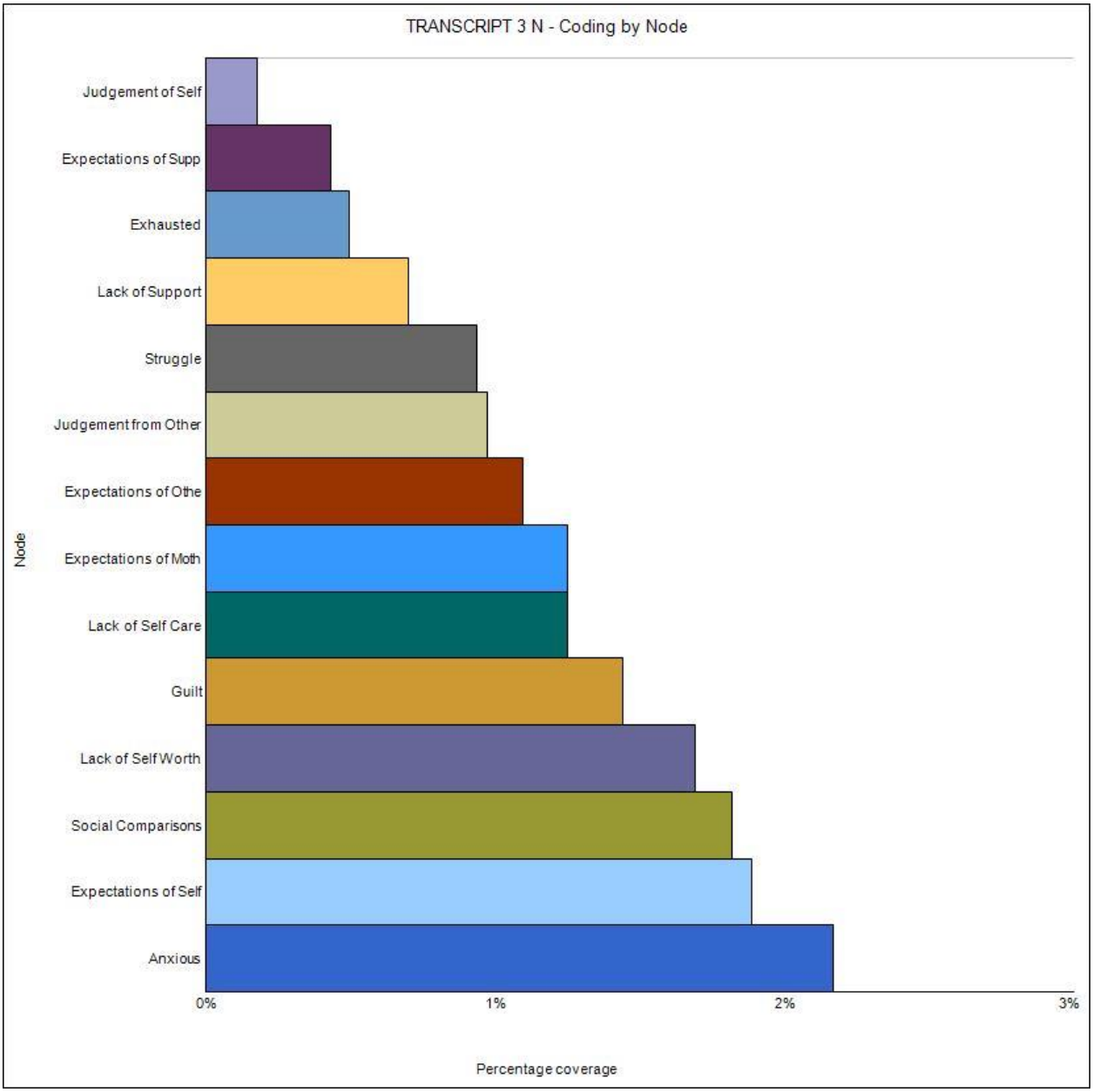
Major Themes Identified for Participant 2

Exhaustion, anxiety, expectations of support, expectations of motherhood, self and others.



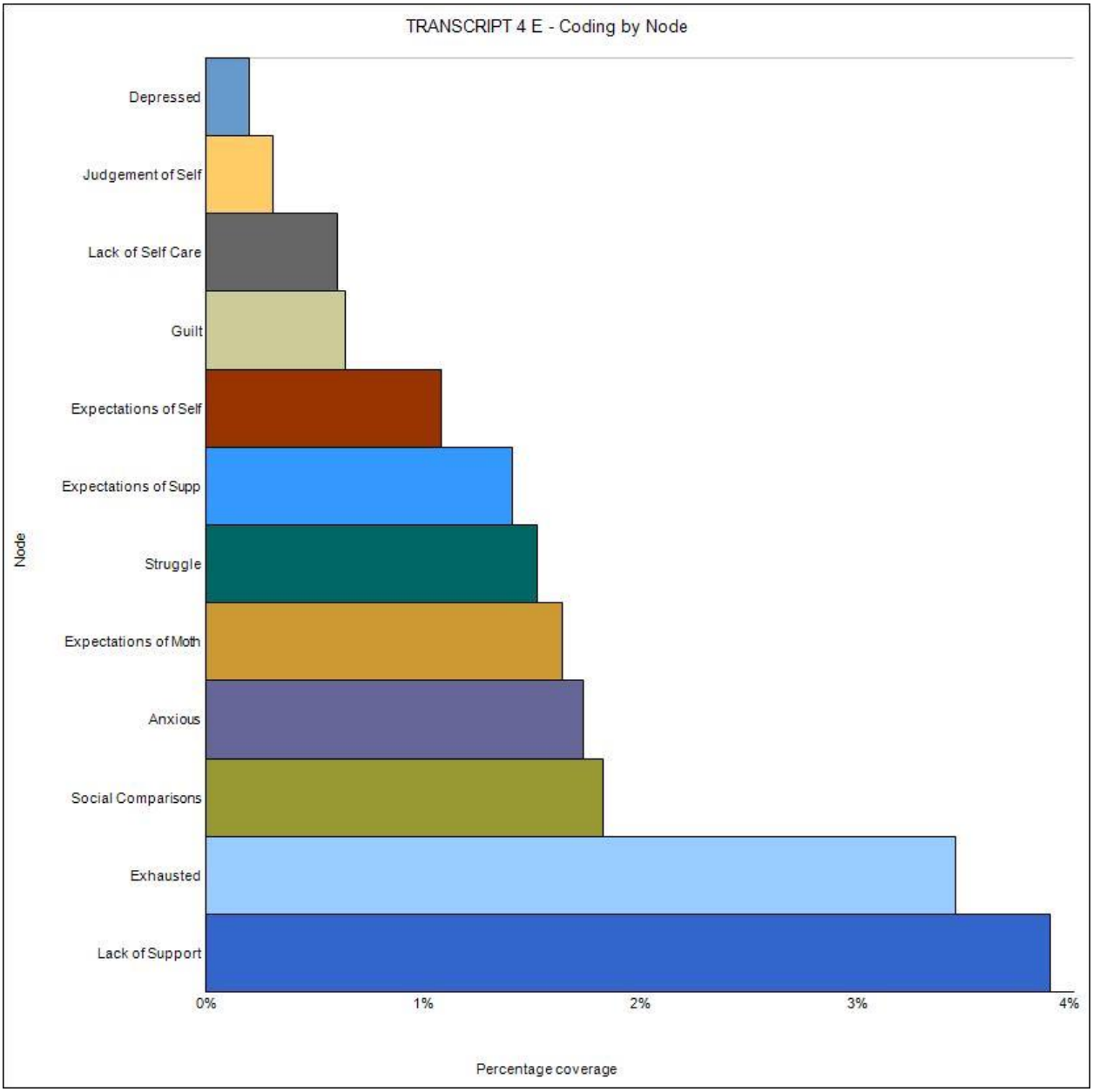
Major Themes Identified for Participant 3

Anxiety, expectations of self, social comparisons, lack of self-worth, guilt and lack of self-care.



Major Themes Identified for Participant 4

Lack of support, exhaustion, social comparisons, anxiety, expectations of motherhood and emotional struggle.



6 Discussion of Findings

This study sought to address the meaning and role of self-compassion in the lives of women who experience anxiety, and or, depression during the perinatal period. The study investigated the overall experience of motherhood, and identified an evident lack of self-compassion in all participants' experiences. This "cast a shadow" over the motherhood experience, and contributed to emotional and psychological struggles for the mothers. Neff (2012) defines self-compassion as consisting of three main elements; self-kindness, common humanity and mindfulness. The three ordinate themes; Emotional Suffering, Unmet Expectations and Unhelpful Views of Self oppose these elements of self-compassion and indicate a lack of self-compassion.

6.1 Unhelpful Views of Self vs Self-kindness

The negative views of self that emerged from judgement of self and judgement from others, along with unhelpful social comparisons, inhibited participants' abilities to engage in self-kindness. Self-kindness has been described as the ability to show kindness to oneself instead of criticism, self-doubt and judgement. According to Neff (2012), self-kindness allows for warmth and understanding in times of suffering, feeling inadequate or when facing fears of failure. Self-kindness allows for the acceptance that experiencing life difficulties is inevitable, but it also increases our ability to self-sooth and nurture ourselves with kindness and care. It also enables us to curtail the effects of judgement and criticism.

6.2 Unmet Expectations vs Common Humanity

Participants reported unmet expectations of self, others and the community, that impacted negatively on their experience of motherhood. These unmet expectations led to feelings of isolation and self-judgement, which contributed to the anxiety, and or, depression they experienced. The common humanity component of self-compassion is the

acceptance and understanding of the shared human experience (not unique to self), including acceptance of suffering in the face of failure, and the ability to deal with unmet expectations with compassion and understanding.

Self-compassion encourages the acceptance of common humanity and recognises that personal failures and life challenges are part of being human. In the case of the participant mothers, the shared experience of unmet expectations from self, others and the community, was a common suffering, a shared experience. They, however, felt alone and isolated in their suffering.

6.3 Emotional Suffering vs Mindfulness

All four participants described overwhelming emotions and a lack of ability to self-sooth in times of emotional suffering. Mothers in this study seemed to over-identify with negative thoughts and feelings, which resulted in rumination and negative views of self. This contributed to their experience of anxiety and or depression.

Mindfulness allows acceptance when experiencing painful feelings and thoughts, and involves being aware of experience in the present moment with clarity and balance. Mindfulness allows one to neither ignore nor fixate on negative life experiences, and fosters a flexible thought process that allows for a non-judgemental acceptance of self (Neff, 2012).

6.4 Lack of Self Compassion vs Self-Compassion

From the evidence provided in this research it is apparent there was a significant lack of self-compassion during the motherhood experiences of the participants. This lack of self-compassion directly impacted, not only the psychological and emotional wellbeing of the mothers, but also made it difficult for the mothers to be fully attuned and sensitive to their babies.

Self-compassion cultivates a healthy and caring relationship towards the self, it also is an essential component of compassion towards others (Hollis-Walker & Colosimo, 2011). In addition to having a positive impact on the motherhood experience by enhancing psychological and emotional well-being, self-compassion, according to Duncan et al. (2009) is a pre-requisite for good parenting. Mothers who are more self-compassionate may be more able to perceive and respond to their child's distress appropriately, and show an increased parental sensitivity. Parental sensitivity allows for maternal attunement to the child, and is the foundation for the formation of a secure attachment. Bogels et al. (2010) suggested self-compassionate mothers are more compassionate and accepting of their child's emotional distress. They hypothesised that the mindfulness component of self-compassion may reduce negative parental ruminations, thereby enabling awareness and facilitating attunement.

7 Strengths and Limitations

This research captured the motherhood experiences of four mothers, and produced a rich, in-depth understanding of the challenges they faced in navigating their way through motherhood. The data gathered from the in-depth interviews identified a lack of self-compassion in all participants' experiences regardless of whether they were first time mothers or third time mothers.

Certain limitations in this research relate to a lack of ethnic, cultural and marginalised diversity of participants. All participants were of a similar age (in their thirties) which may be an influencing factor in the development of self-compassion. Possible impact of the mothers own attachment style was not assessed. This too could be a contributing factor in their lack of self-compassion.

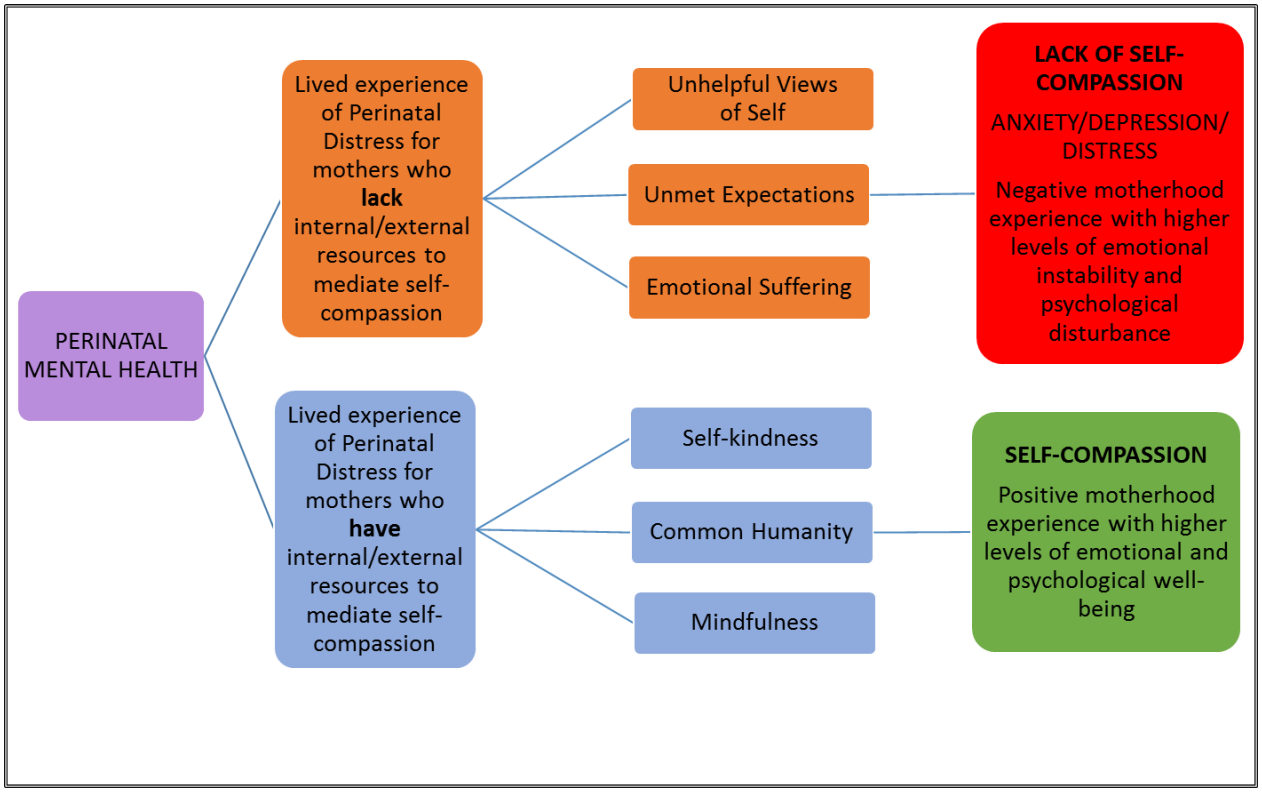
8 Conclusions and Significance

In summary this research identified a lack of self-compassion in the perinatal period "casts a shadow" over the motherhood experience. The major factors that influenced the lack of self-compassion were identified as unhelpful views of self, unmet expectations, and emotional suffering. All of these influences can be addressed through the elements of self-compassion, as identified by Neff (2012), self-kindness, common humanity and mindfulness.

The research presents an opportunity for a conceptual model of the role of self-compassion in the perinatal period to be defined as illustrated in the table below.

8.1 Conceptual Model

THE ROLE OF SELF-COMPASSION IN THE PERINATNAL PERIOD.



8.2 Significance of the study

Although there is a substantial body of recent research providing an insight into the role of self-compassion in psychological wellbeing, there has been no specific research into the role and meaning it plays in the lives of women in the perinatal period.

The findings from this research present an opportunity for further research into the use of self-compassion in the prevention and treatment of perinatal mental health disorders. As stated by (Gilbert, 2009), and (Neff & Germer, 2012), skills of self-compassion can be developed through training programs that teach self-compassion skills. Compassionate Mind Training, a group based therapy, developed by Paul Gilbert to help people develop skills of self-compassion and overcome shame, self-criticism, depression and feelings of inferiority, is one such example (Gilbert, 2009). Kristin Neff and Chris Germer have also designed a self-compassion training program called Mindful Self-Compassion to teach self-compassion skills to the general population. Participants meet for two and a half hours per week for a period of eight weeks and are taught skills of mindfulness, meditation, and are given interpersonal exercises to generate feelings of common humanity (Neff & Germer, 2012).

Evidenced by the body of research on self-compassion, self-compassionate people are more likely to cope with major life stressors and transitions with optimism, resilience, emotional intelligence and greater intellectual flexibility. The transition to motherhood is a major transition and this research offers a greater understanding of the role of self-compassion in the lived experience, and creates an opportunity for the use of self-compassion in perinatal mental health education programs and treatment models.

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10 APPENDIX I

PARTICIPANT INFORMATION SHEET

Self-compassion: what meaning and role does self-compassion play in the lives of women who experience perinatal anxiety and depression?

Dear ……..

You are invited to participate in the research project described below.

What is the project about?

The research project will investigate the meaning and role of self-compassion in the lives of mothers experiencing perinatal anxiety and depression. The main aim of the research is to find out if a lack of self-compassion could be impacting the mental health of mothers in the perinatal period and present an opportunity for self-compassion based therapy to be used in the prevention and treatment of perinatal anxiety and depression.

Who is undertaking the project?

This project is being conducted by Cindy Cranswick and will form the basis for the degree of Master of Philosophy at The University of Notre Dame Australia, under the supervision of Dr. Suzanne Jenkins and Dr. Caroline Bulsara.

What will I be asked to do?

If you consent to take part in this research study, it is important that you understand the purpose of the study and the tasks you will be asked to complete. Please make sure that you ask any questions you may have, and that all your questions have been answered to your satisfaction before you agree to participate.

What it involves:

- A one-on-one interview conducted by the researcher, that will be audio recorded
- You will be asked to share your experience of motherhood with the researcher
- The interview will last between 1 and 1.5 hours
- The interview will take place at a mutually convenient location, date and time.

Are there any risks associated with participating in this project?

The researcher is a qualified professional counsellor and will provide a safe, supportive environment for the interview process. However, it is possible that you may experience some level of anxiety or

stress during the session as a result of some of the questions you will be asked. You will be monitored closely during the session and you are free to withdraw at any time during the session. If any feelings of distress persist after the completion of the session, arrangements will be made for you to be provided with counselling support at Women's Health and Wellbeing Services.

What are the benefits of the research project?

The benefit of the research will be to create new knowledge about the role and meaning that self-compassion plays in the lives of women in the perinatal period who are experiencing anxiety, depression or maternal stress. The findings from this research will present an opportunity for models of therapy based on self-compassion to be used in the prevention and treatment of perinatal mental health disorders.

What if I change my mind?

Participation in this study is completely voluntary. Even if you agree to participate, you can withdraw from the study at any time without discrimination or prejudice. If you withdraw, all information you have provided will be erased.

Will anyone else know the results of the project?

Information gathered about you will be held in strict confidence. This confidence will only be broken if required by law. Only the researcher will have access to your information and the data will be non-identifiable through a system of coding. You will not be identified in any research findings or publications and all data will be stored securely by the researcher.

Once the study is completed, the data collected from you will be de-identified and stored securely in the School of Arts and Sciences at The University of Notre Dame Australia for at least a period of five years. The results of the study will be published as a thesis and a journal article.

Will I be able to find out the results of the project?

Once we have analysed the information from this study we will email you a summary of our findings. You can expect to receive this feedback within one year.

Who do I contact if I have questions about the project?

If you have any questions about this project please feel free to contact either myself cindy.cranswick@nd.edu.au or my supervisor, Dr. Suzanne Jenkins suzanne.jenkins@nd.edu.au . My supervisor and I are happy to discuss with you any concerns you may have about this study.

What if I have a concern or complaint?

The study has been approved by the Human Research Ethics Committee at The University of Notre Dame Australia (approval number 015147F). If you have a concern or complaint regarding the ethical conduct of this research project and would like to speak to an independent person, please contact Notre Dame's Ethics Officer at (+61 8) 9433 0943 or research@nd.edu.au. Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

How do I sign up to participate?

If you are happy to participate, please sign both copies of the consent form, keep one for yourself and mail the other to me in the envelope provided.

Thank you for your time. This sheet is for you to keep.

Yours sincerely,

_____

CINDY CRANSWICK

11 APPENDIX II

CONSENT FORM

Self-compassion: what meaning and role does self-compassion play in the lives of women who experience perinatal anxiety and depression?

- I agree to take part in this research project.
- I have read the Information Sheet provided and been given a full explanation of the purpose of this research project and what is involved in the interview.
- I understand that I will be interviewed and that the interview will be audio recorded.
- The researcher has answered all my questions and has explained possible risks that may arise as a result of the interview and how these risks will be managed.
- I understand that I do not have to answer specific questions if do not want to and may withdraw from participating in the project at any time without prejudice.
- I understand that all information provided by me is treated as confidential and will not be released by the researcher to a third party unless required to do so by law.
- I agree that any research data gathered for the study may be published provided my name or other identifying information is not disclosed.

Name of participant			
Signature of participant		Date	

- I confirm that I have provided the Information Sheet concerning this research project to the above participant, explained what participating involves and have answered all questions asked of me.

Signature of Researcher		Date	