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Maternity care and postnatal depression in Greece:

An ethnographic study.

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ABSTRACT

The overall aim of this study was to explore and to reach an understanding of the quality of maternity care regarding postnatal depression in Greece. Postnatal depression is a severe depressive disorder, which occurs in the postpartum period with its incidence quoted up to 10-15%. Midwives and obstetricians can play a key role in the early detection of postnatal depression by identifying vulnerability factors.

An ethnographic approach was taken in the research design. Midwives and obstetricians formulated the study participants. Non participant observation and interviews were employed as means to explore their perceptions over the particular health care setting and their views on postnatal depression. The data were transcribed and analysed using an inductive approach. Categories and themes were formulated and they represent the key findings that emerged from the study.

An ethnographic analysis gave an illustration of the maternity services in Greece and their ability to deal with postnatal depression. The study demonstrated that the majority of the study participants felt that there was no adequate support regarding postnatal depression. Time constraints, inadequate education, lack of interpersonal relationships, stigmatisation and the involvement of the family were key issues that arose from the study with respect to the care provided towards postnatal depression.

Conclusions drawn from the study imply that both obstetricians and midwives believe that a reorganisation of the service is required that could utilise all their skills and abilities. Continuity of care and a multi-professional team with the involvement of mental health services is suggested so a holistic perspective of care is applied.

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1. INTRODUCTION

Chapter one will introduce a process which brings together knowledge derived from different fields such as nursing science and academic science. This creates a new perspective on a classical issue in the maternity care arena (ie postnatal depression). It is argued that both practical and academic theory are brought together to provide a better understanding of the concept explored.

Information about the nature of the issue and its impact is provided as well as its importance as a strategic benchmark for the quality of maternity care delivered in Greece and elsewhere. An overview of the structure of the thesis is presented given a brief encounter of what is included in the thesis.

1.1 Background

Postnatal depression is a major public health issue and has been explored extensively in the literature especially in terms of prevalence, causes, consequences and treatment. The CEMACH (2006) report identifies suicide as the main cause of maternal death in the twelve months following delivery. Its prevalence is around 13% to 15% and it is confirmed in the majority of the world (Yamashita et al 2000, Beck 2001, Lee et al 2001, Danaci et al 2002, Patel et al 2002). NICE (2007) attempted to reform the maternity care provided with a focus on midwifery. The aim was for every woman to have a named midwife and be present during her labour.

This would formulate a trusting relationship and the woman would feel more comfortable to express her needs (NICE 2007).

Newer policies and guidelines have been put in place over the following years in order to promote maternity care and maternal health. The Royal College of Midwives (1999) concluded that maternal health had an impact on recovery and that postnatal care should be effectively planned. The Antenatal and Postnatal NICE guidelines (2007) were put in place to ensure that most aspects both during antenatal and postnatal period were covered special attention is given to the psychological morbidity following childbirth. A focus on the identification of risk factors from all the health care professionals who are involved in the care given is implemented (NICE 2007). A holistic care approach is proposed and a multidisciplinary effort is suggested for the women to receive adequate care (NICE 2007). Within the UK literature, midwives play the most important role in the provision of maternity care and in the concept of postnatal depression in particular.

The researcher being a midwife herself working in the UK, had ‘first hand’ experience with new mothers, having to look after them during pregnancy, throughout labour and postnatally. Her experience triggered the question ‘why is the mental wellbeing of new mothers to be, not equal to the physical wellbeing?’ As a result of the literature review and in particular the work of Oakley (1980), inspired the researcher to try and explore the above research question further within the context of Greek maternity care. The researcher apart from gaps identified in the

literature, choose the Greek health care system to conduct this study because she wanted to distance herself from personal involvement.

The clinical care provided in Greece is considered to be of high quality, compared to the available resources. Nevertheless, both health care professionals and consumers express feelings of inadequate services (Skalkidis 1996). The focus of the problem is mainly on the operation and harmonisation of the system during the delivery of health care (Skalkidis 1996). Moreover, the Hellenic Society for Quality in Health Care identifies that the systematic research towards the quality of care in Greece is limited in comparison to other European Countries. However, the need to introduce the concept of postnatal depression in practice is important. The main reason for that is a large number of transformations are currently taking place in the Greek national health care system. These transformations impact on the traditional ways of the provision of care, on the relationship between the consumers and health services and on the traditional roles of the health providers (Stavropoulou et al 2007).

An ethnographic approach was used in order to accomplish the research questions. Interviews and observational data were gathered in order to accomplish the aims of the study. Midwives and obstetricians were involved in the study as they are in a key position to identify women who were at most risk of developing postnatal depression, as they were involved in caring for a woman from pregnancy into the postnatal period. The specific clinical situation (postnatal depression) was selected because it is a situation where the available guidance is very limited and therefore the health professional operated in a climate of some uncertainty.

1.2 Purpose of the study

The purpose of the study was to:

- Provide the base for a framework regarding care for women at risk of postnatal depression within the Greek maternity care system
- To make policy recommendations for future service planning
- To add to the body of knowledge in relation to the intersection of health care cultures and systems.
- To assist the researcher to construct a number of questions for further studies.

1.3 Structure of the thesis

Chapter one

The introductory chapter has set out the rationale for undertaking this study. The purpose of the study is also outlined.

Chapter two

Gives a thorough review of the existing literature regarding postnatal depression and the role of midwives and obstetricians towards it.

Chapter three

This chapter analyses the design of the study and offers a discussion of the research process that determined the way that the research was conducted.

Chapter four

Offers an exploration of the research journey and the analysis of the data.

Chapter five

This chapter presents and analyses the findings emerged from the data analysis.

Chapter six

A discussion of the findings is presented in this chapter as well as their connection to the existing literature.

Chapter seven

This chapter gives a summary of the main issues that arose from the study. Finally, it offers recommendations for future research studies.

1.4 The author

I am a researcher of Greek origin, with a background in midwifery and English is my second language. This combination has brought a major challenge. I have had to comprehend complex concepts and present them in an academic language. Working with a foreign language at a high level has required a high degree of concentration to absorb and apply new thinking and writing skills. I have also faced several challenges working across disciplines. One had to do with my profession as a practicing midwife and the preconceptions that might have arisen from it (ie: the most important thing was the health of the mother and the baby). Another one was to acquire an understanding of the way maternity care in Greece was functioning. To deal with these challenges, I have had to instigate several formal and informal meetings with academic colleagues and discussions with my supervisors and midwives and obstetricians. These challenges have encouraged my thinking and broaden my understanding of the concept of maternity care.

2. BACKGROUND OF THE STUDY

2.1 Historical Background

Psychological disturbances following childbirth are not a recent phenomenon. They were first mentioned by ancient Greek physicians and particularly Hippocrates in 400 BC, who debated whether ‘post partum psychosis’ is a specific disease (Kumar 1994). However, they were recorded in detail only in the last two centuries (Holden 1990). Initially all the psychological disturbances during pregnancy and after childbirth used to be summarised under the general term of melancholia (Brockington 1996). Marce and Esquirol, two French psychiatrists in the nineteenth century, attempted the first scientific observations of postpartum mental illness (Cox 1986). Marce described a specific group of psychiatric symptoms that indicate postpartum mental illness. In addition Esquirol noticed that many women with mild or severe psychiatric disorders were cared for at home and therefore no records of their illnesses were kept (Cox 1986). Consequently very little evidence of the treatment provided during this period and the way women responded to it, is in existence. Our understanding of postnatal depression improved significantly only when psychiatry entered its modern phase at around 1950. Since then the volume of research increased greatly and a wide range of treatments became available (Brockington 1996).

In 1955 Hegarty conducted a study on the duration of depression in mothers. The study concentrated on the far-reaching consequences of postnatal depression not only upon the person itself, but also on the family. The sample size was seven women

who had some years earlier suffered postnatal depression. As far as their history and symptoms are concerned these women had many resemblances and they were therefore classified under the term 'post-puerperal recurrent depression' (Hegarty 1955). The symptoms reported by these women were 'sharp faces of depression, tension and irritability', sometimes associated with phobias, excessive fears, hypochondriasis or pre-menstrual exacerbation (Hegarty 1955). It was identified that mother's moody and unpredictable temper was reflected upon the children and the husband prohibiting the family to function as a group. Although the sample size was small, and therefore not representative, Hegarty's (1955) study was important because it focused on the long-term effects of postnatal depression on the life of women and their families.

A few years later Gordon et al (1959) studied the influence of social factors in terms of developing emotional disturbances after childbirth. The authors stated that by identifying the social factors related with the disturbances, physicians would be able to recognise potentially ill patients and achieve a faster recovery. Ninety-eight women were given questionnaire on their social background to be completed before labour. The questionnaire was also completed by a group of fifty-five psychiatric maternity patients. Four months after childbirth the obstetricians who carried out the delivery performed a rating of the degree of emotional disturbance demonstrated by each patient as a reaction to the maternity experience. The rating was on a four-point scale and indicated that 30% of women showed some degree of emotional disturbance after labour (Gordon et al 1959). The number of stressful social events was highly correlated with obstetricians' ratings of normal women's emotional

reactions ($p < 0.001$) as well as with the severity of the patients' disorders ($p < 0.001$). The psychiatric maternity group had much higher scores on the whole than the control group (Gordon et al 1959). These findings were important for physicians to identify women at risk and offer them the chances of therapy as soon as possible.

Pitt (1968) carried out the first major community study on postnatal depression. The sample size was 305 mothers at the antenatal clinic of a London hospital. Mothers had to complete a 24 item depression rating scale on or about the 28th week of pregnancy and then at six to eight weeks after labour. Thirty-three (10.8%) women were diagnosed as suffering from postnatal depression. Women reported symptoms of tearfulness, anxiety, and inability to cope with the baby and sleep disturbances. Pitt (1968) characterised this type of depression as 'atypical depression' because the symptoms were softer than peoples hospitalised in the psychiatric wards. Nevertheless, this study provided the first empirical verification of Esquirol's observations regarding a high incidence of postnatal depression that was generally unreported and untreated.

In addition to psychiatry-based research, work on the psychological aspects of pregnancy and postpartum was also conducted by sociologists and nurses. Sociologists and nurses explored pregnancy and motherhood from different perspectives by emphasising more on the psychological complications after childbirth and the social context of motherhood (Rubin 1967a,b, Rich 1977, Oakley 1980, Oakley 1986,).

Rena Rubin (1967a,b) studied how and by which processes the maternal role is attained. According to Rubin (1967a,b) maternal role expectations follow specific models. In the study 5 primigravidas and 4 multigravidas were interviewed in depth during their pregnancies and the first month after childbirth (Rubin 1967a,b). The results showed a high rate of role-taking items during the neonatal period with the mother role characterised as a 'prototype' (Rubin 1967a,b). Throughout this work the behaviours, manipulations and processes women took up were detected along with the models and referents those women used.

Further sociological research undertook a feminist analysis of motherhood (Rich 1977, Oakley 1980, Oakley 1986,). Rich (1977) mentioned that the responsibility of childrearing is far too heavy and costs the mother both physically and psychologically. It is questioned whether motherhood has to be considered as something 'natural' and 'enjoyable' for the woman (Rich 1977). Women should therefore have the power to control their reproduction activity (Rich 1977). Ann Oakley (1980, 1986) supports Rich's (1977) theories. It is suggested that motherhood is idealised and certain images and descriptions may encourage unrealistic expectations (Oakley 1980, 1986). Oakley (1980, 1986) summarises the importance of childbirth in a woman's life and concludes that easy adaptation especially for primiparas is unusual.

As a consequence of such studies 'postnatal depression' has been established as a household term (Brockington 1996). Health professionals have thus started to pay

more attention to the psychological complications of childbirth, especially to the fairly common postpartum depression.

2.2 Health care system and Maternity Services in Greece

Greece lies at the southeastern tip of Europe, at the southernmost edge of the Balkan Peninsula. The country shares borders to the north with Albania, F.Y.R.O.M., Bulgaria and to the east with Turkey, a total length of 1,228 km. The island of Crete in the south lies between Europe and Africa and the Ionian Sea to the west is the border between Greece and Italy (National Statistical Service of Greece 2008). Greece is a country with a population of 11.000.000 million people. The capital of Greece is Athens, which holds a significant number of the country population (4.000.000 million) (National Statistical Service of Greece 2008). The distribution of the population is 58.8% in urban areas, 12.8% in semi-rural and 28.4% in rural areas. The birth rate of Greece comes up to 9.6 per 1000 inhabitants (National Statistical Service of Greece 2008).

The health care of Greece is based on the National Health System (E.S.Y.), which was first established with its present form in 1981. The E.S.Y. provides coverage for the total population of Greece based on a compulsory social insurance system (Katharaki 2008). The Ministry of Health is responsible for the overall national health strategy and the health policy issues. There are seventeen Regional Health Authorities under the Ministry of Health in an effort to decentralise the system (Katharaki 2008). However, all the decisions, financial matters and administrative

procedures are still under the Ministry of Health (Tountas et al 2002). An approximate number of 112.000 births per year are estimated in Greece which of them an almost 30% was delivered by Caesarean Section (National Statistical Service at Greece 2008). In addition, the proportion of spontaneous onset of labour in Greece lies at 47% compared to Sweden (81%) (Wildman et al 2003). Although the rates of infant and maternal mortality are low, childbirth in Greece is completely medicalised which ended to an increase of Caesarean Sections (Sapountzi-Krepia et al 2006). Midwives, mostly support the obstetricians who perform the vast majority of deliveries in Greece (Sapountzi-Krepia et al 2006).

Limited economic resources, a restricted number of beds and a geographically unequal distribution of both staff and patients are some of the problems characterising the Greek Health Care System (Katharaki 2008). Those are similar problems affecting the services in obstetrics and gynaecology (Katharaki 2008). Rural areas are affected the most by not having enough providers specialised in obstetric issues compared to big cities and that causes difficulties to women who have to go to the hospital for their pregnancy follow up and delivery (Katharaki 2008). A comparative study of thirty-two public hospitals performed in order to estimate the efficiency of Greek Obstetric Units. The study focused on decision making and efficiency optimisation. Data obtained from official public sources and from the Yearbook of Health published from the Ministry of Health (Katharaki 2008). Additional data obtained from the hospital themselves. The focus of the particular study was primarily managerial as the data acquired concerned the number of beds, the numbers of medical personnel and the expenses for the provision of care

(Katharaki 2008). However, the study showed that the available resources in rural areas were limited and for that reason women had to travel in bigger cities in order to receive adequate care regarding their pregnancy (Katharaki 2008). That might result in overcrowded hospitals and limited staff and beds to accommodate all the women and offer adequate care.

Sapountzi-Krepia et al (2009) conducted a study which aimed to translate and evaluate the Kuopio Instrument for Mothers (KIM). KIM was firstly used in Finland and is a self-report tool enclosing questions regarding demographic characteristics, marital status, education, employment characteristics of the participants, maternity welfare clinic services and birth. One hundred and seventy seven women who had given birth one week to six months earlier participated initially in the study and were asked to complete the questionnaire (Sapountzi-Krepia et al 2009). They were also asked to complete the questionnaire once again one to two weeks later and return it to the researchers. Seventy seven women returned the complete questionnaire and those were the results used for the data analysis (Sapountzi-Krepia et al 2009). The results indicated that the majority of women would prefer a hospital birth than a homebirth and that they trust their doctor and they would follow his advice without question (Sapountzi-Krepia et al 2009). However, the aim of the study was different and the researchers achieved a good overall test-retest reliability and a good understanding by the Greek women. Nonetheless, the sample size was small and therefore, not representative to the Greek population and thus more longitudinal studies required (Sapountzi-Krepia et al 2009). In Greece, literature that examines the nursing and midwifery care (not from a medical or an epidemiological

perspective) provided to women, as well as studies on the expectations, needs and experiences of maternity services users is almost non-existent (Sapountzi-Krepia et al 2009).

3. THEORETICAL PERSPECTIVE

Sociology has always regarded the division of labour as a crucial tool in understanding broad collective structures. Emil Durkheim considers the specialised *division of labour* as the most important characteristic of industrial societies (Taylor et al 1999). Nevertheless, as commented by Gibbs (2003), Durkheim does not provide an explicit definition for the term, but simply focuses on the multiplicity of occupations as the underlying *degree* of the division of labour. The limited division of labour characterizing pre-industrial societies necessitated a societal cohesion based on *mechanical solidarity*, i.e. the fact that members of a group share very similar work and life experiences, leading to coherent values and beliefs (Barnes 1966). By comparison, industrial societies require a much broader range of occupations and labour becomes increasingly specialised (Taylor et al 1999). In spite of this fragmentation, Durkheim suggests that the enhanced division of labour could lead to a new form of social cohesion founded on the renegotiation of the interdependence of the various specialist occupations. Societal cohesion is thus based on *organic solidarity* (Taylor et al 1999).

Durkheim, in agreement with Marx, believed that the necessity to produce the means of subsistence is *the* most fundamental aspect of human existence (Allen et al 2005). Both consequently recognised that the way in which a society organises the totality of activity necessary to existence is the starting point for understanding such a structure (Barnes 1966, Allen et al 2005). Despite their very different theoretical aims, both Durkheim and Marx recognise the importance of the totality of activities

necessary in a particular society, whether paid or unpaid, forming part of the private, public or voluntary sectors (Allen et al 2005). Such an approach focuses on the formation of various occupations, their organisation and structure, and also the evolution of the division of labour over time and the laws governing such change (Allen et al 2005). Moreover, it emphasizes the dynamic relationships between the various activities and the underlying moral division of labour within a broad work organization (Allen et al 2005).

In *The Hospital and its Negotiated Order* Strauss et al (1963) found that there were no specific rules defining the behaviour of staff and patients. Staff shared the goal of improving patients' health and returning them to the community, but there was significant disagreement on the means by which this can be achieved. It was noted that an array of professions with different approaches worked together, without a unambiguous agreement on the central issue of care (e.g. forms of treatment). In this context the division of labour can be conceptualised as a social system impacted upon by external and internal forces that are capable of reshaping occupational boundaries (Allen 2001).

Due to the multiplicity of specialised work involved, healthcare has become a popular ground for studying the dynamics of integration of a variety of occupations into a coherently operating society (Dingwall et al 1983). The healthcare environment provides a uniquely complex array of societal and cultural norms, legal external and internal, formal and informal regulations, and a testing ground for professional and societal boundaries, between health providers and patients and their

advocates (Benoit et al 2005). Participation in such social entities provides a point of reference from which individuals are able to evaluate their own contribution and ultimately acquire a distinct identity (Murray et al 2005). Healthcare thus provides a natural laboratory for the investigation of a multitude of classic sociological problems and potentially the evolution of new analytical tools. Such a diversity of factors make the study of healthcare provision a challenging undertaking, particularly with respect to the ultimate aim of providing a more effective and efficient service for the patient.

Allen (1977) studied the doctor-nurse relationship focusing on certain features of hospital work which inhibit face-to-face inter-occupational negotiations, but which resulted in the readjustment of the formal division of labour between the two groups. The study, based on ethnographic data generated in a surgical and a medical ward in a UK District General Hospital, focused on nurses' day-to-day accomplishment of occupational jurisdiction. Employing a perspective in which the division of labour was conceptualised in dynamic terms, nursing work was examined through the analysis of five boundaries: nurse-doctor; nurse-patient/relative; nurse-nurse; nurse-support worker and nurse-management. Occupational boundaries and roles, were shown to be non self-evident but actively negotiated entities within a system of work. Jurisdiction therefore has to be claimed and sustained in the work arena (Abbott 1988).

Existing theories of healthcare organisation have difficulty in explaining specific issues of care provision, such as the variation in the organisation of maternity

services across developed welfare states. In a study of maternity care provision in four high-income countries (United Kingdom (UK), Finland, the Netherlands and Canada) Benoit et al. (2005) found that in all four cases the profession of midwifery, “a female-dominated occupation serving an exclusively female clientele”, was the ‘touchstone’ for exploring the origins of diversity. The social position of midwifery reveals a society’s fundamental cultural ideas about women as: (1) autonomous (or not) professionals in the maternity division of labour and as (2) legitimate (or not) recipients of midwifery care services across the childbearing period (Benoit et al., 2005). By studying the social role of midwifery we can gain insights beyond what social or health policy perspectives allow. More specifically, within the framework of maternity care provision, we can gain better understanding of the operation of jurisdictional boundaries and the way governmental regulation, health professionals and clients mould maternity care systems (Benoit et al 2005). The way in which the welfare state legislates midwifery, self-imposed professional boundaries within the maternity care domain, and public support of midwifery and maternity issues, are essentially correlated in effecting any changes (Benoit et al., 2005).

Implications of the process of privatisation of a national healthcare system on the delivery, organisation and, ultimately, the outcome of services has been studied by Murray et al (2005) on the obstetric practice in Chile. The study clarifies the interrelationships between the *macro-level* of political decisions, the *meso-level* of the organisations through which government reforms were enacted, and the *micro-level* of clinical practice (Murray et al 2005). As a result of privatization, a significant proportion of Chilean women seeking maternity care, gained improved access and apparently a more-personalised relationship with specialists, while at the

same time, practitioners' efforts to rationalise their workload resulted in increased medical interventions in childbirth, in the form of planned caesarean sections and assisted deliveries (Murray et al 2005).

The healthcare environment has been significantly altered by the introduction of new medical technologies, leading to changes in working practices and the division of labour (Atkinson 1995). The new challenges associated with the acquisition of new skills, has in some cases impacted on professional autonomy (Atkinson 1995), as new technologies have an important impact on the ways in which we work and how we work with others (Heath *et al.* 2003). The growing establishment of preset care protocols, and treatment pathways also have a crucial impact on the allocation of resources and the establishment of lines of accountability (Heath et al 2003). Ultimately, the particular organizational structures within which healthcare is provided influence the diagnostic process, and the management and treatment of illnesses.

4 LITERATURE REVIEW

4.1 Introduction

Pregnancy and childbirth are complex events involving significant physiological and psychological changes. They both represent vulnerable periods for women owing to rapid biological and emotional transitions (Brockington 1996, Mauthner 1997). Being directly involved with pregnancy and childrearing mothers might be vulnerable to experience a psychiatric disorder (Brockington 1996). There are different types of postnatal illness including ‘maternity blues’, ‘postnatal depression’ and ‘puerperal psychosis’, which are distinguished in terms of severity and persistence (Boyce 1996).

‘Maternity blues’, should be differentiated from postnatal depression and clarify the boundaries between them. ‘Maternity blues’ is a condition affecting up to 70% of women after childbirth and the symptoms are present mostly in the first ten days after delivery (Welford 1998, Spinelli 1998, Pritchard et al 1996). Pregnancy and childbirth are major life events affecting women’s lives (Welford 1998). Therefore, a low mood disorder it is likely to be natural, having to cope with a new situation (a baby) and an unfamiliar environment (the maternity unit, other mothers and hospital staff) (Welford 1998). Main symptoms are tearfulness, emotional lability, anxiety, irritability, hypochondriasis and sleep disturbance (Harris 1994, Prithcard et al 1996, Welford 1998). The aetiology is more related to hormonal, biological and psychosocial factors (Pritchard et al 1996, Harris 1994, Welford 1998). The

advantage with 'maternity blues' is that the symptoms are generally resolved by the tenth day and they do not necessitate specific treatment (Drugs and Therapeutics Bulletin 2000). The new mother might question her capability and she needs to be reassured that this is a normal symptomatology and it should not prevent her from enjoying her new baby (Kelly et al 2001). Therefore, there is a need for encouragement to the mother and the family and to distinguish 'maternity blues' from more severe depression.

Conversely, 'puerperal psychosis' is a severe depression with other psychotic features that can risk the lives of both mother and baby (Gaskell 1999, Prithcard et al 1996, Boyce 1996). Its incidence, however, is low, at between one and two per thousand deliveries, and appears within the first two to three weeks after delivery (Boyce 1996). 'Puerperal psychosis' is known to be caused by biological and other factors and is attributed mainly to a family or personal history of bipolar illness, primiparity and perinatal mortality (Prithcard et al 1996, Gaskell 1999). The symptoms of 'puerperal psychosis' are delusions, visual and auditory hallucinations, intrusive thoughts, delusions of guilt, unusual beliefs, disturbed sleep, impaired concentration and low or increased energy levels (Prithcard et al 1996, Gaskell 1999). 'Puerperal psychosis' is a difficult situation that requires hospitalisation and medication such as antidepressants and mood stabilisers (Spinelli 1998). Depending on the symptoms infant protection may be required to avoid the danger of the mother hurting her infant (Spinelli 1998).

Postnatal depression is of serious concern, its incidence quoted in the literature is about 10-15% of all mothers, and its duration could be from six months to one year (Cox 1996, Cooper and Murray 1995). O'Hara and Swain (1996) in a meta-analysis of 59 studies, state that despite the different methods used, the incidence of postnatal depression was similar giving a mean of 13%. Although, there is an argument from Ghubash and Abou-Saleh (1997) that the vast majority of these studies were coming from Europe and North America. Nevertheless, there is Kumar's (1994) earlier work, 'Postnatal mental illness: a transcultural perspective' who via a critical review of the literature, attempted to notice the incidence of postnatal depression in different countries up to that date. It is indicated that 'surprisingly' there were no significant differences reported amongst the studies available (Kumar et al 1995). Later studies confirm the incidence quoted above as well as the assumption that it is a global phenomenon (Abou-Saleh et al 1997, Cooper et al 1999, Nahas et al 1999, Yamashita et al 2000, Beck 2001, Lee et al 2001, Danaci et al 2002, Patel et al 2002). Amongst the studies identified there is a cross-cultural study from Thorpe et al (1992) between Greece and UK which reveals a 12% incidence. Therefore, postnatal depression is a phenomenon concerns not only Western European and North American countries, but probably in every country and culture. Nonetheless, a transcultural approach is needed not only to examine the prevalence of postnatal depression, but also to see the way the socio cultural context affects the incidence as well as the perceptions towards motherhood and mental health illnesses.

Postnatal depression will be the focus of the present study since it is evidently a fairly common phenomenon that can affect women during an extensive period after childbirth.

The American Psychiatric Association (DSM IV 2000) and the WHO (ICD-10 1993) classify postnatal depression under mood disorders but not as a formal diagnosis. Its onset lies between four to six weeks after childbirth and the symptoms do not differ from non-postpartum mood episodes. However, there is a distinction between minor and major postnatal depression. Major postnatal depression is exclusively diagnosed either by a clinical diagnosis according to the criteria established in the DSM IV, ICD, or on depression instrument scores such as the EPDS (Cox 1996)

The symptoms include tearfulness, apathy, low mood, extreme fatigue, anorexia, insomnia, loss of enjoyment, lack of interest and impaired concentration (DSM IV 2000). Thoughts of self-harm or suicide as feelings of failure and guilt may accompany these symptoms (DSM IV 2000). Additionally, postpartum onset mood episodes could be presented with or without psychotic features (DSM IV 2000).

The Harvard Guide to Psychiatry (1999) presents the same criteria for major depressive episode but in a more analytic way:

1. Depressive mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful).

2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being seek).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

(The Harvard Guide to Psychiatry 1999, p:282)

The above criteria could be used as a tool for differential diagnosis regarding other postpartum episodes such as maternity blues and puerperal psychosis.

Although, the aetiology of postnatal depression remains debatable, the most important risk factors are considered to be a history of psychiatric disorder (usually depression), lack of social support, dysfunctional relationship and child rearing (O'Hara and Swain 1996, Cooper et al 1998). No significant differences related to hormonal changes were found between women with postnatal depression and women

without (Harris et al 1996). However, thyroid dysfunction is a hormonal factor that has been associated with an increased risk of developing postnatal depression (Harris 1996). Kumar (1994) criticises the existing studies to this area as their validity depends on the methodological instrument they use. He suggests the lone use of self-report questionnaires as a limitation of the studies. However, he supports the fact that there is a common ground on the aetiologies of postnatal depression.

Postnatal depression is not just a maternal problem, but also a family problem. Besides its effects on the partners, a major issue is the detrimental effect that the mother's depression can have on the child's social and intellectual development as Murray et al 1996, Kumar 1997, Sharp et al 1995 tried to prove through self-report studies. Hence, early detection if not prevention, should be therefore the primary concern of all the health professionals involved in pregnancy and childbirth (Cox and Holden 1996). Although, the definition of the health professionals involved might be different according to the health care system of each country. In Greece in particular, midwives and obstetricians are in a key position to identify women who are at most risk of developing postnatal depression, as they are involved in caring for a woman from pregnancy into the postnatal period.

4.2 Factors influencing postnatal depression

4.2.1 Risk Factors

It is generally recognised that postnatal depression is caused by a combination of biological and psychosocial factors (Beck 2001). More controversial evidence suggests that genetic and hormonal factors may contribute to as much as one third of the aetiology of postnatal depression (Lee et al 2007).

4.2.1.1 Biological factors

Hormonal changes are associated with pregnancy and especially the rapid changes in progesterone and oestrogen levels during childbirth (Harris 1994, Zonana et al 2005). Endocrine changes during pregnancy are mainly an outcome of placenta activity as described by O'Brien and Pitt (1996) who acknowledged the fact that mental disturbance might result from the rapid fall of oestrogen and progesterone levels after labour and the women's difficulty to adjust to these changes. In contrast, cortisol levels rise slower than the other steroid hormones during pregnancy, maintaining a diurnal variation until partuition. They rise further during labour and subsequently return to normal levels within approximately 15 days (O'Brien and Pitt 1996).

Harris et al (1996) conducted a survey evaluating the connection between mood at 5-6 weeks postpartum and peripartum saliva hormone profiles, particularly cortisol and progesterone. The study involved 120 primigravida women. Inclusion criteria were the absence of any kind of major marital, socioeconomic or health problem (Harris et al 1996). Women had to collect saliva twice a day starting 2 weeks before the expected day of labour until day 35 postpartum. They also completed certain

depression rating scales (Harris et al 1996). The saliva samples were analysed by highly sensitive radioimmunoassays, which guaranteed the reproducibility of results accurately characterising free hormone profiles over multiple samples.

The results for the 1st and 14th pre-natal days and the first postpartum day were consistent with each other. Postpartum depression was not significantly associated with plasma (total) cortisol at various times (Harris et al 1996). Moreover, no association was identified between postnatal depression and progesterone levels or the rapidity of decline in the first 35 postpartum days. Additionally, measurements were conducted only until the 35th day postpartum so that there are no results for depression cases developed later (Harris et al 1996). This work was in line with a previous study where no significant association was found between cortisol level and depression (Harris et al 1989). Yet, as it is suggested in later studies, negative findings were yielded regarding oestrogen and progesterone as potential biological factors (Zonana et al 2005).

On the other hand, the prevalence of thyroid dysfunction increases after childbirth and postpartum thyroiditis is a recognized clinical entity, where the condition is more frequent in women expressing thyroid antibodies early in pregnancy (Stagnaro-Green 2004). Although depressive symptomatology is common in thyroid dysfunction, many studies trying to link postpartum mood disorders with thyroid dysfunction reported conflicting results (Bloch et al. 2003). Some reports suggested an association of postpartum depression with overt thyroid dysfunction or with the mere presence of thyroid antibodies even during early pregnancy (Harris et al 1992, Harris

1994, Kuijpers et al 2001). Kuijpers et al (2001) stated that their study was the first with a prospective design, using a multivariate model which shows a relationship between the presence of thyroid peroxidase antibodies during gestation and the subsequent development of a depressive episode after delivery. Other well known determinants of depression such as family history, marital status, personal habits and employment status were taken into account to formulate a multivariate model (Kuijpers et al 2001). However, the sample size was rather small and all the presumed biological factors were not included in the analysis, which means that the association between thyroid autoimmunity and depression should be interpreted with caution.

Similar results supporting the association between thyroid function and postpartum mood were identified by a cross sectional study which conducted in Greece (Lambrinouadaki et al 2010). Fifty seven Greek women were evaluated for postpartum mood swings by the Maternity Blues Questionnaire and the Edinburgh Postnatal Depression Scale on the first and sixth week postpartum. Serum Free T4, Free T3 and TSH concentrations as well as thyroglobulin and thyroid peroxidase antibodies were measured on admission for delivery and daily until the fourth postpartum day. The association between hormone and antibody levels were examined, and scores in the two scales evaluating postpartum mood disturbances (Lambrinouadaki et al 2010). A limitation of the study is that it was not possible to obtain all the samples of serum concentrations at six weeks as many women did not respond (Lambrinouadaki et al 2010). In addition the sample was very small to generalise so, if there are hints of such evidence it could be beneficial to conduct a larger study and identify if such an association is indeed present. If such a

relationship is proven, screening of thyroid function during a routine antenatal visit might prove useful in assessing the risk for postpartum depression.

Nonetheless, it seems logical that not only the psychosocial factors are examined but the hormonal as well. As Harris (1996) states:

There must be a delicate balance and interaction between biological and environmental stressors in the context of pregnancy. This means that a global approach is necessary when dealing with the various mental states which occur particularly after delivery, ie. Attention should be given to each and every potential cause of mental disorder not excluding, or only concentrating on, the biological factors.

(Harris 1996, p:35)

4.2.1.3 Psychosocial factors

Previous psychiatric history

A psychiatric history commonly reported to be a risk factor for postnatal depression, especially a history of depressive disorder (Cooper et al 1995, 1996, 1998, McGuffin et al 2006). Studies consistently show that having previously experienced depressive symptoms at any time, not just related to childbirth leads to a significantly increased risk of postpartum depression (O'Hara and Swain 1996, Beck 2001, Johnstone et al 2001, Josefsson et al 2002). According to Brockington (1996), previous history of depression considered as common, especially in multigravida women. This observation was the first to be made in the history of pregnancy-related mental illness (Brockington 1996).

The current evidence from large-scale studies suggests that having a positive family history of any psychiatric illness confers risk of postpartum depression, although the effect size is small (Johnstone et al 2001, Josefsson et al 2002). Johnstone et al (2001) conducted a large prospective study on 490 women. The sample included women who were planning to give birth in four participating hospitals. A questionnaire administered within one-week postpartum, attained information regarding women's personality, psychiatric history and life events (Johnstone et al 2001). In addition, the Edinburgh Postnatal Depression Scale used to assess the women's depressive status eight weeks after delivery. The familial history of mental illness, anxiety or the history of depression, were accounted as risk factors for the development of postnatal depression (Johnstone et al 2001). Similarly, Josefsson et al (2002) identified that a history of a psychiatric disorder could play a substantial role towards the onset of postpartum depression. The advantage of this study was the large number of participants eligible for the study (n=1558). The sample comprises the total population of pregnant women (gestational week 35-36), registered at the antenatal care clinics in the southeast region of Sweden (Josefsson et al 2002). The Edinburgh Postnatal Depression Scale used to assess the 1489 women participated in the study at six to eight weeks postpartum and, or, six months postpartum from two of the four communities were selected as an index group (n=132) (Josefsson et al 2002). A control group of 264 women randomly selected from all four communities. The researchers extracted their data from the official records during pregnancy, delivery and the puerperium of each woman participated. Socio-demographic characteristics, number of induced abortions, miscarriages, any history of infertility, psychiatric disorder, obstetric complications, number of visits at the antenatal clinic before delivery, pregnancy complications, sick leave during pregnancy and perinatal

events obtained (Josefsson et al 2002). All the data were analysed using the SPSS program. Sick leave during pregnancy and number of visits at the antenatal clinic were the variables strongly associated to postpartum depressive symptoms for all women (Josefsson et al 2002). The main reasons for sick leave were psychiatric disorders and pregnancy related complications. However, as stated, an underestimation of an earlier or ongoing psychiatric condition might have influenced the results and that could be a potential weakness of the study (Josefsson et al 2002).

McGuffin et al (2006) provided evidence for the familiarity of postpartum depression. One hundred and twenty sibling pairs recruited for the study via the community mental health teams and via advertisements. The women targeted had to meet the DSM-IV and ICD-10 criteria for major recurrent episode and they had to have at least one sibling meeting the same criteria (McGuffin et al 2006). The subjects of the study were all of British origin and above eighteen years old. DSM-IV defines the onset of postpartum depression from four weeks to six months postpartum. The criteria for each pregnancy assessment followed firstly the narrow definition of the four weeks onset and secondly the broader one of within six months onset (McGuffin et al 2006). Structured written vignettes assembled all information available and consensus ratings and best – estimate lifetime diagnoses including postpartum episodes used from the researchers in order to obtain their results. The results of the study suggested that a subgroup of women with major depression have a specific vulnerability to the triggering episodes by childbirth (McGuffin et al 2006). Yet, the evidence presented was significant when the onset of postpartum depression was established at six to eight weeks postpartum rather than the four weeks suggested by the DSM-IV. Although O'Hara and Swain (1996) did not

support the family history as an important risk factor for postnatal depression, this could be subject to substantial methodological differences such as the definition of postpartum depression and the methods used to assess postnatal depression. Nevertheless, the particular study (McGuffin et al 2006) provides strong evidence that a personal history of a major depressive episode might be an important risk factor for the development of postnatal depression.

Life events

Experiences such as the death of a loved one, relationship breakdown or divorce, losing a job, or moving home are known to cause stress and can trigger depressive episodes in individuals with no previous history of affective disturbance (Robertson et al 2004). Robertson et al (2004) in a literature review synthesis of risk factors towards postnatal depression identified that the study design is important in the assessment of a probable association between life events and the onset of postnatal depression. Studies using retrospective data collection could direct the participants to over report life events and link them as potential causes of postnatal depression. On the contrary, this kind of bias could be eliminated by employing prospective data where the result is not already known (Robertson et al 2004).

Boyce et al (2005) in their study included four hundred and twenty five women assessed with the EPDS on two occasions plus they should have met the criteria for major depression. Out of them forty two were identified to be cases of postnatal depression. The experience of one or more life events was identified as a significant

risk factors associated with the development of postnatal depression. Similarly, O'Hara and Swain (1996) reviewed fifteen studies which involved more than one thousand participants and they used prospectively recorded data on life events. Apart from the other risk factors named, a rather strong relationship between experiencing a life event and developing postpartum depression was identified (O'Hara and Swain 1996). As Robertson et al (2004) stated in their review, contrary studies that took place in Britain or North America, Asian studies showed no significant association between postnatal depression and life events. Mohammad et al (2010) in their prospective cross sectional study did not report recent life events as a potential risk factor to develop postpartum depression. This is contrary to the review of Klainin et al (2009), which included all the English written Asian studies, that explore the risk factors on postpartum depression amongst Asian countries. The effects of psychological factors on postnatal depression were investigated in forty three studies (Klainin et al 2009). Stressful life events were one of the strong risk factors consistently arising as a strong predictor of postpartum depression. Recent life events should therefore be taken into account during pregnancy, as a marker of the women's psychological status.

Marital relationship

Marital problems during pregnancy and following childbirth have been reported to play an important role in the development of postnatal depression. Reviews conducted on postpartum depression have confirmed that marital difficulties could affect women's psychology and have consequences to their mental health status (O'Hara and Swain 1996, Beck 2001, Robertson et al 2004). An explanation given is

that women might have feelings of isolation and lack of support as a newborn could have an effect a couple's daily life.

According to Boyce (1996) women suffering from postnatal depression were likely to describe their relationship as lacking intimacy and their partners as uncaring or feeling unloved. Boyce gave a representative example of how unsupported women express themselves:

“...the labour and delivery were normal and the first few weeks postpartum went well. Denise became increasingly depressed over the next few months, her self-esteem fell and she experienced difficulty coping with the baby. Her husband helped around the house, yet didn't appreciate what she was experiencing. She felt unable to talk to him about her activities during the day and, when she did, he appeared bored. He would however delight in telling her what an interesting day he had. After he returned from work, he would say to his wife, 'What useful things have you done today?' she felt devastated by this lack of emotional support from him and became increasingly depressed.”

(Boyce 1996 In: Cox et al p:95)

It is more or less obvious that women need this kind of emotional support so that they do not feel isolated. This shows that childbirth can bring a reorganisation in the household and more traditional roles to be adopted. Women are those who usually get the greater share of parenting tasks and men are mostly involved with the financial support of the family. In addition, the last few decades the nuclear family has replaced the extended family and the importance of a stable relationship is, therefore, increased (Taylor et al 1999).

Hock et al (1995) conducted a longitudinal study that assessed the marital satisfaction and the support of traditional sex role beliefs regarding marital context and its importance in predicting maternal depressive symptomatology. Traditional sex role beliefs referred to preconceived expectations regarding the responsibilities and obligations that each partner could assume within the marital relationship (Hock et al 1995, p:79). The sample size used in the study was one hundred and forty two first time mothers and their husbands/partners. Participants were asked to complete a set of questionnaires during the third trimester of pregnancy, at six weeks and at nine months postpartum. Hock et al (1995) indicated in their study that the sample size used was considered to be representative to the whole population of a large city where the study was performed. However, couples from ethnic minorities, teenage or single parents were excluded from their study, hence, the results could not be generalised to these specific groups. The results demonstrated that maternal depressive symptomatology was unrelated to marital satisfaction before birth. By contrast, the relation between symptoms of depression and maternal satisfaction was significant at nine months postpartum (Hock et al 1995). It is possible that women felt that they had to cope with the provision of care towards the newborn and that their needs for support, communication and sympathy had not been met from their partners. Interestingly, husbands/partners of mothers who experienced depressive symptomatology, reported less marital satisfaction and expressed more traditional views regarding their role. Thus, both marital dissatisfaction and traditional sex role attitude with regards to marriage are considered to be risk factors associated with the development of postnatal depression. Milgrom et al (2008) in their large prospective study, sustains that partner's support could be considered as a core risk factor that might lead to postnatal depression. In addition, Milgrom et al (2008) refer to the

importance of social support as another strong risk factor, similarly to Robertson et al (2004).

Social support

Several studies have evaluated the role of social support through friends, family or any kind of network and its benefits in terms of reducing the risk to develop postpartum depression (Beck 2001, Milgrom et al 2008, Grussu et al 2009, Mohammad et al 2010). Robertson et al (2004) classifies social support into different types such as informational (advice given), instrumental (practical help) and emotional (expressions of care).

Rogan et al (1997) used a grounded theory analysis of the experience of 55 first time mothers. The aim of this work was to extend the analysis and explain the application of a 'paradigm model' and the identification of a Basic Social Process (BSP). The BSP involves at least two clear phases and is the evolution that occurs as people respond to given phenomena and move from one phase to another (Strauss and Corbin 1990 cited in: Rogan et al 1997). The method used was focus groups discussions. Rogan et al (1997) analysed the literature on early motherhood from the point of view of nursing, midwifery, feminist, and sociological research. The results showed that mothers used to characterise the social support received as fairly good or inadequate (Rogan et al 1997). Women mentioned that coping with both the baby and housework was causing them much stress (Rogan et al 1997). Women reported feelings of exhaustion, disorganisation, confusion, loss of control, isolation,

loneliness, that their lives became different, and they felt unready for motherhood (Rogan et al 1997). Women identified a lack of social support towards caring for the baby (bathing, changing, coping with crying, explore baby's behaviour) and how to seek information and facility to express themselves whenever they felt unwell (Rogan et al 1997). Association of lack of social support and postnatal depression was similarly established in other studies, e.g. Murray et al (1995) and Webster et al (2000).

Grussu et al 2009 conducted a retrospective study employing two hundred and ninety seven Italian women attending antenatal classes. The Postpartum Depression Predictors Inventory used to identify risk factors on the ninth month of pregnancy. The EPDS and a 12-item General Health Questionnaire used to screen and identify women with a higher symptomatology of postnatal depression after childbirth and repeated the EPDS screening six to eight weeks postpartum (Grussu et al 2009). The study excluded women with psychological problems. Women were divided into two groups after the completion of the first screening (higher symptomatology and lower symptomatology). The prevalence of higher symptomatology at six to eight weeks postpartum was around thirteen percent, which is similar to the rates mentioned in the bibliography (O'Hara and Swain 1996). Education, prenatal anxiety and friends support were identified as significant risk factors for the women with higher scores (Grussu et al 2009). Women felt that it was very important to have friends that they would be sympathetic, supportive and trustworthy so they could freely confide all their anxieties and expect support and understanding in return (Grussu et al 2009). A reason this might be happening is that Italy (Jardri et al 2006), similarly to Greece (Gonidakis et al 2008), is moving away from the extended family towards the

nuclear family model. This might be leading pregnant women to rely mostly in friends rather than their family members as they might have done before.

Similarly Mohammed et al (2010) in their prospective cross sectional study of prevalence and factors regarding antenatal and postnatal depression identified that lack of social support played an important role that could lead to the development of postnatal depression. Three hundred and fifty three women were recruited antenatally and screened with the Edinburgh Postnatal Depression Scale (EPDS), Depression Anxiety and Stress Scale (DASS-21), Maternity Social Support Scale (MSSS), Cambridge Worry Scale (CWS), Perceived Self-Efficacy Scale (PSES) and Perceived Knowledge Scale (PKS) (Mohammed et al 2010). Interviews with the women were held in the antenatal clinic and they included demographic data, obstetric history, feelings regarding the current pregnancy, and information on the marital and in-law relationship (Mohammed et al 2010). Women were screened again at six to eight weeks postpartum with the use of the EPDS. Data revealed that women expressed that lack of support during labour and birth, lack of parenting skills, lack of emotional and social support and their relationship with their mother in law were significant factors that could lead in the development of postnatal depression (Mohammed et al 2010). Women felt that there was a lack of emotional care, support and provision of information during childbirth. In addition, women felt emotionally distressed trying to maintain their relationship with their mother in law (Mohammed et al 2010). In Middle Eastern countries women have to oblige with the mother in law's will as they have a significant influence on their son's (Mohammed et al 2010). Irrespective of the place of residence, the way women perceive the concept of social support is an important factor that determines their wellbeing.

Socioeconomic status

Literature suggests that unemployment might affect mental health via various mechanisms (O'Hara et al 1996; Brown et al 1997, Kumar 1994). The lack of money could lead to several types of deprivation, difficult living conditions or poor housing (O'Hara et al 1996, Brown et al 1997, Kumar 1994). Unemployment and low income have been cited as risk factors in mental health disorders and depression in particular (Ryan et al 2005). The meta-analysis of O'Hara and Swain (1996), Beck (2001), Robertson et al (2004) and Ryan et al (2005) demonstrated that financial difficulties might not be a strong risk factor in the development of postnatal depression but it is definitely a significant one.

The transition from childhood to adulthood is full of psychological and physiological changes. Teenage girls have to face both changes due to pregnancy and their own maturity (Birch 1997). Such physical and mental changes, together with new responsibilities and the stress of adjustment to parenthood, could affect the health of teenage mothers. Irvine et al (1997) states that teenage pregnant girls could face clinical depression and depressive symptomatology in the year after delivery. This may be due to the fact that teenage mothers often lose contact with friends, become socially isolated and feel disadvantaged with regard to the social support including finances, welfare services and family. The findings of Irvine et al (1997) were supported by the study of Deal et al (1998). Deal et al (1998) identified that maternal depression is related to poor social support and dependence on public assistance. It is also stated that young mothers in their study were mostly unmarried and had low educational level and employment status ((Deal et al 1998). This may be likely

because most teenage pregnancies are unplanned and teenage mothers are economically disadvantaged (Irvine et al 1997). Teenagers under 16 have not finished school and their qualifications are limited so that their employment opportunities are reduced (NHS Centre for Reviews and Dissemination 1997).

Saurel-Cubizolles et al (2000) conducted a survey investigating unemployment as a cause of psychological distress on young mothers in France. The sample consisted of six hundred and thirty two first and second time mothers who were interviewed three times (Saurel-Cubizolles et al 2000). The methods used were face to face interviews at birth and postal questionnaires five months and twelve months after childbirth. Although the sample size could not be considered as representative to the whole population, it is similar to previous national studies operated in France concerning first and second time mothers (Saurel-Cubizolles et al 2000). The rates of psychological distress were significantly higher among unemployed women (48.9%) than among the employed (30.5%) and housewives (35.7%). Unemployed mothers expressed feelings of depression or sadness more frequently than women from the other two groups did and generally they were presenting their mental health as poorer during the past year (Saurel-Cubizolles et al 2000). Unemployed women were more often young women, under 25, with a low educational level, lone mothers and with their first baby (Saurel-Cubizolles et al 2000). Negative consequences for both the mother and the baby are particularly evident in the case of single mothers that lack support (Lane et al 1997).

Although rates of prenatal and postnatal depression in developing countries are high, little is known about the factors predicting the persistence of prenatal depression beyond the first few postnatal months (Rahman et al 2007). A longitudinal study was drawn by Rahman et al (2007) in order to identify the factors contributing to postnatal depression persistent. Seven hundred and one women in a rural sub-district of Pakistan recruited for the study and the Schedule for Clinical Assessment in Neuropsychiatry (SCAN) was used to identify those with ICD-10 depressive disorder in the third trimester of pregnancy (n=160). Depressed women were re-assessed at three, six and twelve months postpartum (Rahman et al 2007). Women who were depressed at all time points were compared with the remainder. Poverty was found to be a detrimental factor for these women not to recover from postnatal depression. In addition, poverty was one of the risk factors responsible for the development of postnatal depression. The high number of children in the family as well as the lack of support from their husbands' and low educational level was other risk factors contributing to the development of postnatal depression and its slow recovery (Rahman et al 2007). The researchers claim that this was the first study from the developing world exploring the course of prenatal depression and factors predicting its persistence during the first year following childbirth. The study was community based and used standardised and valid instruments to diagnose depression. Therefore, the cost of childcare and the access in 'goods' (e.g. food, housing), increase the levels of anxiety and stress for women.

Obstetric factors

Obstetric factors including pregnancy-related complications such as preeclampsia, hyperemesis, premature labour, delivery-related complications, such as caesarean section, instrumental delivery, premature delivery and bleeding have been examined as potential risk factors for postpartum depression (Robertson et al 2004). Forman et al (2000), Johnstone et al (2001), Josefsson et al (2003) indicated that pregnancy-and delivery-related complications have a small but significant effect on the development of postpartum depression. Carter et al (2006) reviewed twenty four studies that have examined the association between caesarean section and postnatal depression. The results were not consistent as fifteen studies found no significant association, five found a significant association and four had mixed results (Carter et al 2006). A possible explanation for the discrepancies might be the methodological weaknesses some studies present (Carter et al 2006). Moreover, it is unclear if delivery complications or long and painful labour leading to emergency procedures account for the association (Breeze et al 2006). Hence, the evidence suggests that obstetric factors play only a small but significant role to the development of postpartum depression. Caution is, however, required when interpreting these results as all external variables need to be taken into account.

4.3 The Edinburgh Postnatal Depression Scale

A well known tool is the Edinburgh Postnatal Depression Scale which is a 10-item self-report_questionnaire used as a screening instrument for the identification of postnatal depression (Cox et al 1987). Women's responses to each variable are

scored from 0 to 3, resulting in a final score between 0 and 30 (Cox et al 1987). The higher the score, the more likely are the mother depressed (Cox et al 1987). One of the draw backs of this method however is that the EPDS does not give the opportunity to the mothers to directly talk about their feelings, but it gives the mothers a chance to think of what mostly worries them and to express it afterwards (Mauthner 1997).

Studies using EPDS have shown that it is not only easy to complete but is also widely acceptable by women who regard themselves as being unwell (Drug and Therapeutic Bulletin 2000, Cox 1996). Research from Hearn et al (1998), aiming at showing the effectiveness of EPDS as a screening tool, detected women with postnatal depression which were not identified earlier by the primary health care team. One hundred and seventy-six women completed the EPDS up to the 42nd day after their delivery and were followed by postnatal examinations. Midwives, health visitors and GPs were asked to report if they were aware of any woman with mental health problems before the women completed the EPDS, following which the results were matched. However, due to the sensitivity of the topic there were some ethical concerns involved.

The results showed that 30/176 mothers scored more than 12 in the EPDS, which means that they were characterised as depressed (Hearn et al 1998). However, nearly half of them were not recognised to be depressed by the primary health care team. Deserving particular mention are the 137 mothers who were followed by midwives,

as only 4 of the 15 were perceived to have a mental health problems (Hearn et al 1998). One of the limitations of this study is that the researchers included mothers attending postnatal visits and not those who do not attend. This fact is quite important since it is stated in literature that postnatally depressed women tend to visit the clinics less frequently than women who are not depressed (Seeley et al 1996). As recognition of mental health problems is not easy, the results of this study only consolidate the point that the use of a detective tool is a necessity in identifying early postnatal depression. Ward (1999) points out the existence of training courses available to health professionals for the use of the EPDS.

Evins et al (2000) findings also support those of Hearn et al (1998). Throughout their study Evins et al (2000) showed that the EPDS is a simple and effective tool to administer both from the point of view of the health professionals as well as the mothers. The only concern expressed in both studies was the effectiveness of EPDS in non-English speaking women or emigrants (Evins et al 2000, Hearn et al 1998). A few attempts have been made in UK for validating the EPDS in non-British communities (Clifford et al 1999, Clifford et al 1997). On the basis of these results it is suggested that language is not the only problem that exists, but the cultural background of the woman also has an impact on the administration of EPDS (Clifford et al 1999).

Therefore, it is essential that midwives should always be aware of every woman's different cultural background during their care. This is something that midwives

should inform all the other health profession they have a liaison, especially health visitors that they replace midwives after the first month of pregnancy (Knott et al 1999). Midwives should have a liaison with the health visitors and inform them about the psychological needs of every woman (Ward 1999). Combining 'listening visits' with the use of the EPDS, midwives would be in a position to have a clear opinion about the woman's needs and transfer it to the health visitor whom has to continue the later stage of early motherhood.

The studies that have demonstrated that even if often contact between the women and the health professionals was taking place, there were lots of undetected cases. This means that EPDS is an effective tool and should be used from all the primary health care team professionals. Midwives should be aware of the EPDS and use it to all the postpartum women they are in contact. Midwives should also make an effort to follow up women that they do not attend postnatal clinics regularly.

4.4 Consequences

The impact of social and emotional behavior of depressed mother to the infant and the possible correlation with defects in functionality has been the subject of extensive study. The newborn is dependent on the mother and consequently all her features and behavior seems to affect it in terms of cognitive, emotional development and behaviour (Murray 1992, O'Connor 2002). An understanding of the difficulties in the mother-infant interaction in the context of postnatal depression is important because

of the possible implications for the long term development of the child (Murray et al 1996).

The studies of Murray formed a great contribution to research on the effects of postnatal depression on the cognitive development of the children. In her first study in 1992 she assessed the impact of postnatal depression on cognitive and motor development, language skills, as well as the concept object task at 9 and 18 months of the infant's life (Murray 1992). The evaluation of this task, when examining whether the infant knows that the objects continue to 'exist and remain in the mind' or even disappear from his field, found that children of mothers who had experienced postpartum depression episode were more likely to fail the test (Murray 1992). This, however, did not occur in children of mothers who had depression not in the postpartum period. It was also found that girls were less affected by the mother's emotional state (Murray et al 1992). As far as the conceptual development and language skills of children are concerned, postpartum maternal depression had no effect. These parameters appear to be more affected by the social and educational level of the mother (Murray 1992).

Similarly, Sharp et al (1995) conducted a study to investigate the children of 204 mothers who had previously participated in a study of their mental health during pregnancy and the first postnatal year. The main focus of the study was to examine the extent to which maternal illness affects girls and boys differently in terms of the childrearing practices they experienced and their intellectual outcomes (Sharp et al 1995). One hundred and seventy two children, 170 mothers, and 99 fathers were assessed when the children were 3 years and 10 months. The results showed that

boys of mothers depressed in the first year postpartum scored approximately 1 standard deviation lower on standardised tests of intellectual attainment than boys whose mothers were well that year (n=26), (n=34) retrospectively (Sharp et al 1995). On the contrary the score for the girls of whom the mothers were depressed in the first year was higher (n=34) and for those who were not depressed (n=41) retrospectively. This difference between boys and girls cannot be fully explained. One possible explanation is that boys maturation is delayed compared to girls so it is likely for the girls to have the ability to cope easily with the mothers illness and her behaviour (Sharp et al 1995).

Later in 1996, Murray et al followed up 180 high-risk and 43 low-risk primiparous women and their offspring investigating the development of postnatal depression. The main focus of the study was the impact of maternal mood disorder on the infant at two and eighteen months postpartum (Murray et al 1996). The findings suggested that there was a poor relationship between the mother and the baby especially the first two months (Murray et al 1996). However, the study did not come up with significant results about the consequences this kind of interaction might have in the child's development (Murray et al 1996). It was concluded that there should be other risk factors combining with postnatal depression, which affect the child's development (e.g. family environment, financial situation) (Murray et al 1996). Literature suggests that children with postnatally depressed mothers are showing fewer positive facial expressions associated with more drowsy, fussy and less relaxed behaviour (Murray 1997, Edhborg 2000). Hence, it is more likely that depressed

mothers affect children's' mood with their own behaviour which might cause problems to their emotional and cognitive development.

Sinclair and Murray (1998) in their study tried to explore the effects of postnatal depression on children's adjustment to school. According to the findings, no relationship was found between maternal postnatal depression and the teachers' assessments of the children's 'readiness for school' (Sinclair and Murray 1998). Such 'readiness' was, however, influenced by the social class of the family and by the child's gender. The only significant relationship between the teachers' ratings of 'personal maturity' and the explanatory variables was a positive correlation with recent maternal depression (Sinclair and Murray 1998). Girls were rated as significantly more 'adaptable' than boys were. The mean score for girls on this dimension was 52.9%, and for the boys the mean was 46.7%. The effects of postnatal depression were almost evident among boys and those from lower social class families. Thus, among boys from lower social class families, 50% of those whose mothers had been postnatally depressed showed definite behavioural disturbance and a further 20% were rated as probably disturbed. On the contrary, girls of postnatal depressed women were less distractible, and they had the lowest scores on the measure of hyperactivity (Sinclair and Murray 1998). Such findings highlight the need for resources to support mothers of young children for the children to have fewer problems in their adjustment to school.

Colding et al (2001) designed the Avon Longitudinal Study of Parents and Children (ALSPAC) as part of the European Longitudinal Study of Pregnancy and Childhood (ELSPAC), focused on the identification of environmental features (i.e. ‘the conditions or influences under which any person or thing lives or is developed’), that affect the health and development of children. Participating women needed to be residing in Avon while pregnant, and their expected date of delivery to lie between 1st April 1991 and 31st December 1992 (Colding et al 2001). Women resident in the Avon area that left soon after enrolment were omitted from any follow-up. Information was collected from early pregnancy using various means: (i) questionnaires to be completed by the mothers, their partners and children from age 5; (ii) medical, educational and other records; (iii) various measures of environmental conditions at home, such as levels of air pollutants, magnetic radiation and noise; (iv) frequent, direct evaluation of a 10% sample of the study (randomly selected) at ages starting at 4 months to 5 years; (v) in-depth interviews, focusing on particular sub-groups; (vi) direct assessments of the entire study on an annual basis and in a controlled environment from ages 7 years onwards; and (vii) obtaining biological samples from the mother, her partner and the child (Colding et al 2001). Leading up to the study, comprehensive data on ~10,000 children and their parents had been collected from early pregnancy until children ages between 8 and 9. The study by Colding et al (2001) intended to collect further detailed data on the children through puberty. Changes in anthropometry, attitudes and behaviour, fitness and cardiovascular risk factors, bone mineralisation, allergic symptoms and mental health were of particular interest. The study provided extensive data on additional features, such as medication, symptoms, diet and lifestyle, attitudes and behaviour, social and

environmental features, and importantly remained unbiased by parental knowledge of any future problems the child might develop (Coliding et al 2001).

The possibility that antenatal maternal anxiety could be associated with emotional and behavioural problems in children was investigated by O'Connor et al (2002), within the ALSPAC study. The sample was 7448 responses in the form of postal-collected questionnaires. Maternal depression and anxiety were evaluated at 18 weeks' and 32 weeks' gestation, and at 8 weeks, 8 months, 21 months and 33 months postnatally. Children's behavioural and emotional issues were evaluated at 47 months (O'Connor et al 2002). The Crown-Crisp index was employed to measure maternal anxiety, whereas the Edinburgh Postnatal Depression Scale was used to assess depression. Significant associations between antenatal anxiety and children's behavioural and emotional problems at age 4 years were established (O'Connor et al 2002). These involved a range of behavioural issues in both boys and girls. These issues generally persisted when other risks (e.g., antenatal, obstetric and socio-demographic) were controlled for, as well as a level of postnatal anxiety and depression (O'Connor et al 2002). Importantly, higher levels of anxiety in late pregnancy were shown to be associated with hyperactivity and inattention in boys, and global behavioural and emotional issues for both boys and girls. These results were statistically unrelated to postnatal anxiety, suggesting that there is direct causality between antenatal anxiety and behavioural issues in children (O'Connor et al 2002).

The ALSPAC study focused also on the paternal depression following childbirth and its possible association with the emotional development of the child. According to Ramchandani et al (2005), adolescent children of depressed fathers were more likely to exhibit forms of psychopathology. The ALSPAC study suggested that paternal depression postnatally is associated with an increased risk of emotional and behavioural problems at age 3.5 years (Ramchandani et al 2005). The sample included 13,351 mothers and 12,884 fathers, all of which were evaluated at 8 weeks postnatally by employing the Edinburgh Postnatal Depression Scale (EPDS). Fathers were assessed further when children reached 21 months of age. Children's emotional and behavioral development was measured by the Rutter revised preschool scales. Further information for 8431 fathers, 11,833 mothers, and 10,024 children was available (Ramchandani et al 2005).

Symptomatic depression was a significant factor in abandoning the study after 42 months for mothers, but not for fathers, although EPDS scores correlated to a significant degree for both groups (Ramchandani et al 2005). Importantly, paternal depression was shown to correlate with higher total problem scores on the Rutter preschool scales. Similar association was established in emotional, conduct, and hyperactivity scores but not in the case of prosocial behavior scores (Ramchandani et al 2005). Associations remained significant even after adjustment for social class, degree of education, and maternal depression. Paternal depression at 21 months postnatally correlated with subsequent conduct problems and hyperactivity. Associations between paternal depression and later behavioral problems was shown to be stronger in boys than in girls (Ramchandani et al 2005).

One of the first studies to investigate individual and combined effects of postpartum depression in mothers and fathers was performed by Paulson et al (2006), in 2-caregiver families with 9-month-old children, in a large, nationally representative sample across the United States. The study utilised initial data from the Early Childhood Longitudinal Study (ECLS)-Birth Cohort, for children born in 2001, sampled from the National Center for Health Statistics vital statistics system (Paulson et al 2006). Data were collected from mothers, resident and non-resident fathers, and infants. This was achieved by combining computer-assisted personal interviews, self-administered questionnaires, and direct developmental assessments of the infants. The study by Paulson et al (2006) used data from the biological mother interviews and self-report questionnaires and resident father questionnaires, generating a sample of 5089 individuals. This study extended results by the Early Childhood Longitudinal Study (ECLS) Birth Cohort, by examining the individual and combined effects of both maternal and paternal depressive symptoms on their parenting performance during the postpartum period (Paulson et al 2006).

It was shown that when both parents were depressed, the child was less likely to be put to sleep on his/her back, less likely to have ever been breastfed, and more likely to be put to bed with a bottle (Paulson et al 2006). A notable exception was that the child was more likely to be put to bed awake, when only the fathers were depressed, in agreement with anticipatory guidance for promoting good sleep habits in children. By comparison, these findings also indicate that maternal postpartum depression may hinder mothers from adhering to anticipatory guidance recommendations (Paulson et al 2006). It should be noted, however, that the particular study employed the CES-D

D to assess parental depression, a measure that is not accepted as an affirmed clinical diagnosis. Moreover, measures of parenting performance are limited by the fact that they are based on parental self-reporting (Paulson et al 2006).

Problems with infant sleep in combination with postnatal depression can have an adverse effect on the infant, the mother, and the mother–infant relationship (Hiscock and Wake 2001). Disrupted sleep can lead to deterioration of mood, cognition, and motor function (Pilcher and Huffcutt 1996). Such symptoms are similar to those associated with postnatal depression. Similarly, infants with sleep difficulties are likely to be tired, irritable and inattentive, exhibiting difficulty in modulating their impulses and emotions (Hiscock and Wake 2001). By comparison, children of mothers with depression exhibit similar issues as well as poorer cognitive and behavioral outcomes and attachment difficulties. Importantly, mothers who assess their sleep quality as good or very good were less likely to report depressive symptoms, even when they reported their infant's sleep to be problematic (Hiscock and Wake 2001, Hiscock et al 2008). It was shown that behavioral interventions by specialists, such as a child nurse or paediatrician could improve maternal depression symptoms and assert a positive effect on mother-infant relationship (Hiscock et al 2008). Symon et al 2012 noted improvement on sleep patterns as well after a 45 minute consultation offered by a General Practitioner. In addition a significant improvement on the maternal psychological well being and reduction of anxiety was noted (Symon et al 2012).

A 2-year follow-up study by Sutter-Dallay et al (2011) on a cohort of mothers and their children, employed repeated measures of maternal depressive symptoms and infant functioning, to investigate whether early maternal depressive symptoms (6 weeks postpartum) were associated with poor cognitive or motor development in the child, and also, whether such associations were related to the maternal depressive status over the period of the follow-up. Associations were adjusted for demographic variables that have been found to possibly affect infant developmental outcome (e.g., maternal education, SES) (Sutter-Dallay et al 2011). In a prospective, longitudinal study, mothers and children were followed-up from birth to 2 years; repeated measures of PNDS were made using the Edinburgh Postnatal Depression Scale (EPDS); child development was assessed using the Bayley Scales II. Multilevel modelling techniques were used to examine the association between 6 week PNDS, and child development, taking subsequent depressive symptoms into account (Sutter-Dallay et al 2011). The mother–infant dyads were then assessed over a 2-year follow up period, at 3 days, 6 weeks, 3, 6, 12, 18 and 24 months after delivery. Of the 598 women completing the assessment in pregnancy, only those who completed at least one EPDS over the follow-up period were considered in the present study (Sutter-Dallay et al 2011). The sample for data analyses included 515 mothers of 269 (53.2%) boys and 246 (47.8%) girls. The severity of PNDS 6 weeks after delivery predicted lower child cognitive performance over the follow-up. By contrast, no association was found between PNDS 6 weeks after delivery and child motor performance over the follow-up (Sutter-Dallay et al 2011).

Notably, and highlighting the importance of taking account of subsequent maternal depressive symptoms, the severity of PNDS 6 weeks after delivery strongly predicted

EPDS score at all follow-up assessments after adjustment for child gender, maternal age, educational level, mean income and parity (Sutter-Dallay et al 2011). No concurrent association was found between EPDS scores over the follow-up and child cognitive. After adjustment for EPDS score at the time of infant assessment, the association between PNDS 6 weeks after delivery and child cognitive performance was reduced to trend level, and the association between PNDS 6 weeks after delivery and motor performance remained non significant (Sutter-Dallay et al 2011). The present study showed that maternal depressive symptoms at 6 weeks postpartum significantly predicted poorer cognitive performance in the children over a 2-year follow-up. However, this association was reduced to a trend when maternal depressive symptoms over the follow-up period were taken into account (Sutter-Dallay et al 2011). Thus, the association between early depressive symptoms and poor child cognitive outcome was partly explained by the presence of maternal depressive symptoms over the 2 years following birth (Sutter-Dallay et al 2011).

The current study had a number of strengths: the present study combined a large sample size with repeated assessments of maternal mood over the course of the follow-up, with repeated, independent, assessments of infant and child development (Sutter-Dallay et al 2011). Furthermore, Sutter-Dallay et al (2011) were careful to include consideration of a range of demographic and infant characteristics that could potentially confound the interpretation of any associations between maternal depressed mood and adverse child outcome. It seems likely that effective interventions for parental depression would lessen its adverse effects on subsequent childhood development, particularly in boys.

4.5 The role of midwives towards postnatal depression

Mental health problems are distressing at any time of life, but they may bear greater impact during pregnancy and the postnatal period (Miles 2011). Early detection, which can facilitate effective treatment are consequently essential in managing a spectrum of postnatal mental health problems, ranging from baby blues to psychosis. In order to provide thorough and effective care, midwives need a comprehensive knowledge and understanding of the psychological changes that occur for women during pregnancy and the postnatal period (Miles 2011). According to ACNM (2008) the woman's right to self-determination, informed choice and decision making are fundamental in establishing viable routes of communication. In this context, it is essential to initiate discussions on perinatal mental health, diagnostic modalities for postnatal depression, provide information about treatment options and community resources, provide counselling and facilitate referral based on specific needs (ACNM 2008). It is also fundamental to help women to overcome barriers of social stigma and cultural differences. The role of the midwife is therefore central in providing evidence-based support for women with postnatal depression and to provide a full range of options, such as counselling and support groups (ACNM 2008). The fulfilment of the midwife's role can be achieved only through trust, which is based on collaboration with the woman, continuity of care, sharing of information and counselling (ACNM 2008).

In line with Naidoo et al (2000), a health professional in order to give the right information he or she should target the 'risk group' and identify its needs. The idea of 'risk group' has been established in order to direct health promotion activities to

people most in need (Naidoo et al 2000). For example the midwife should be aware of the risk factors that might cause postpartum mental disorders and try to identify women that belong to this category. To achieve this the woman has to be placed 'in the centre' of the maternity service provided (DoH 1993). The woman's 'felt needs' was initially assessed by listening directly to her requirements from the service. Guidelines on how the service should run was subsequently produced as a response to the 'expressed needs'. Subsequently gaps and inequality of provision in the service were identified through the assessment of 'comparative needs'. This approach was based on the fact that every woman needs information to make a choice about the various aspects of maternity care (NICE 2007).

Hillan et al (2000) in their study tried to see the woman-centre approach not from the women's point of view, but from the midwives. It is very important not to look at things from one perspective only, because there must be a combination of both sides for a better outcome. Hillan et al (2000) aimed to explore the midwives perceptions on the changes that happened to the maternity services. One of the main objectives was to look at the midwives' views towards a woman-centre approach (Hillan et al 2000). The sample size was 877 midwife members of the RCM in Scotland. The sample size was satisfactory, although it could not be characterised as representative of the whole population. The researchers used questionnaires as a data collection tool containing mostly close questions. However, there was plenty of space for midwives to expand their own ideas (Hillan et al 2000). The results showed that over 56% of midwives mentioned that policies towards pregnant women were improved a lot during the last few years where the woman-centre approach was practised (Hillan et

al 2000). Midwives emphasised the need for women not to see too many health professionals during pregnancy because, they could end up with conflicting advice. Ninety seven per cent of midwives felt that they were the professional group that should take care of pregnant women, but 96% suggested that a collaboration between midwives, obstetricians and GPs would be beneficial (Hillan et al 2000). This point is fundamental for women's care because it is likely that they would ask questions coming up with different answers and it might end up in confusion and low self-esteem.

A range of non pharmacological interventions in order to deal with postnatal depression is suggested by NICE guidelines (2007). Emotional and practical support on aspects of the infant care does not require specific training and can therefore be offered by various healthcare professionals (NICE 2007). Of similar importance is the educational component that could focus on preparation for childbirth, the postnatal period and the role of parental adjustment. Continuity of midwifery care following delivery and hospital discharge is considered to be of primary importance as part of providing broader psychological support and potential intervention (NICE 2007).

Continuity of care provision within different service configurations has been investigated in various studies. Marks et al (2003) assessed the efficiency of continuous midwifery care with regards to the reduction of postnatal depression rates in women with previous history of depression. Fifty one pregnant women out of 98 were randomly selected during their antenatal booking to receive continuous

midwifery care with the remaining ones getting standard antenatal care (Marks et al 2003). After completing several assessments it was concluded that continuous midwifery care had no impact on psychiatric outcome. In particular there were no differences between total rates of conditions treated, or rates in groupings associated with social adversity, antenatal or postnatal depression, depressions that emerged post-booking, and the duration of depressive episodes (Marks et al 2003). However, continuous midwifery care was very successful at engaging women in treatment and therefore was an important factor in supporting mental health care for women of child-bearing age (Marks et al 2003).

Early postnatal period is a transitory stage for a woman which is of paramount importance since it not only allows her time to recover from childbirth but also to adapt to her new role as a mother. This adaptation is very essential as it has a great impact on the well being of the newborn baby. (Anderson et al 2000). New mothers need continuous reassurance that all their postnatal problems will be detected early and treated in the best possible way (RCM 1999, NICE 2007). It is very important for new mothers to feel confident about their physical and emotional well being, as this will directly have an impact in the new-borns health. There are many problems women might face after delivery mainly physical such as breast conditions, painful stitches and backache (Anderson et al 2000). However, conditions pertaining to mental health could be over shadowed by physical illness. Therefore, in order to tackle mental health conditions the care of the mother during the postnatal period should be carefully designed and delivered (Dennis 2005).

The health care providers should be aware of the fact that the needs of every woman are different and therefore should be tailored individually (DoH 1993). Midwives should be most aware of this fact since they are in the forefront of care providers, being involved extensively in the first 10 to 28 days after delivery, which is the early postpartum period (DoH 1993). During this time period the midwives should ensure a comprehensive care plan encompassing both the physical and emotional needs of the woman (Anderson et al 2000). With regards to the role of midwives, Kumar et al (1995) considers them the best people who can 'pick up' women 'at risk' of developing postnatal depression at an early stage and promptly refer them to a specialist. However, midwives should be aware of distinguishing the fatigue and emotional lability a woman is likely to experience after childbirth from postnatal depression (Mauthner 1997). This requires an extensive knowledge as far as the symptomatology of postnatal depression is concerned.

Singh et al (2000) conducted a study, administering a short questionnaire to 960 women in order to examine whether the postnatal care needs of women were met satisfactorily. The number of participants was statistically significant. Almost half of the participants mentioned, were happy with the care they received with regards to their physical needs however care pertaining to emotional needs left much to be desired. The chief complaint was that the midwives could not devote enough time to address their emotional concerns (Singh et al 2000). This fact is understandable since the time allocated by each midwife to a mother was limited and was mainly used to focus on the physical needs. On the other hand community midwives were likely to have spent more time with the mother than the hospital staff resulting in a more

satisfactory care (Singh et al 2000).

A novel model of midwifery-led postnatal community care was studied in a large cluster randomised trial by MacArthur et al (2002). This model involved extended midwifery contact to 28 days, with a final midwife contact at 10–12 weeks, which replaced the appointment with the family doctor at six to eight weeks. Physical and Mental Health Components scores of the SF36 (PCS and MCS) and the EPDS were obtained at 4 and 12 months postnatally. No differences in PCS scores were identified at 4 and 12 months post-birth. Further outcomes, such as physical morbidities at 12 months post-birth, indicated no statistically significant differences other than fatigue and haemorrhoids. Significant differences were identified by MacArthur et al (2002) in maternal mental health at 4 and 12 months postnatally following community based intervention. Although the study by MacArthur et al. (2002) illustrated that postnatal extension of midwifery care could be beneficial for women, issues regarding the cost involved need to be assessed by the service providers before implementing these suggestions.

A systematic review conducted by Dennis (2005) in order to assess the effects of psychosocial and psychological interventions in comparison to the typical antenatal, intrapartum or postnatal care on the risk of postnatal depression. One hundred and fifty five studies were identified of which ninety nine were excluded as non-experimental (Dennis 2005). Of the fifty six studies retrieved, only fifteen included in the study as the rest were not in line with the author's inclusion criteria (eg methodological quality) (Dennis 2005). Nevertheless, 7697 women were included as

subjects in the meta-analysis of the remaining fifteen studies. The studies were categorised to examine specific types of psychosocial and psychological interventions. Psychosocial interventions included antenatal and postnatal classes, home visits, continuity of care and early postpartum follow up. On the other hand, psychological interventions included debriefing, and interpersonal psychotherapy (Dennis 2005). Clear evidence was not identified by the systematic review in order to implement antenatal and postnatal classes, early postpartum follow up, continuity of care models, debriefing in hospital and interpersonal psychotherapy as means of preventing postnatal depression (Dennis 2005). However, interventions that were initiated postnatally or were individually based were more likely to be beneficial (Dennis 2005). This might be because in a review of sixteen antenatal screening tools done by Dennis (2005), none of them presented with the acceptable validity to accurately define women at risk of developing postnatal depression.

The importance of postnatal midwifery care provision within NICE guidelines was also studied by Bick et al (2012). Following an increase in complaints from women regarding their postnatal care (e.g. lack of support in breastfeeding) during hospital stay, the authors concentrated on the revision of the ongoing practices in order to enhance maternal postnatal care and identify possible barriers (Bick et al 2012). A model of continuous quality improvement (CQI) was used for this purpose as it is presumed that the upgrading of quality is a constant process. Inclusion criteria to the specific study were: women older than 16 years of age, who delivered a full term healthy infant as well as the demonstration of their ability to read and write in English (Bick et al 2012). A pre and post survey of women performed at ten days and

three months in order to gather comparable information regarding breastfeeding, maternal health outcomes and experiences of care.

Various adjustments had to be made in terms of everyday practice such as longer stay on delivery suite to initiate breastfeeding after birth and promote skin to skin contact (Bick et al 2012). In addition, in the consultant led unit, women's care was handed over from obstetricians to midwives as soon as possible after birth. Also, an electronic postnatal discharge initiated on delivery suite to be completed at the time women left the hospital (Bick et al 2012). An information leaflet regarding care on the postnatal ward was distributed to parents alongside with practical sessions regarding infant care. Midwives and maternity support workers had to attend several workshops in order to implement the new changes (Bick et al 2012). The study of postnatal maternal records endeavored to detect maternal morbidity. Moreover, the EPDS was used to assess psychological health as part of the maternal morbidity (Bick et al 2012).

Out of 1160 women recruited for the study, 725 returned the 10 day questionnaire with 575 returning the three months questionnaire completed. Results showed that mothers enjoying all the interventions implemented, were more likely to initiate breastfeeding and continue with exclusive breastfeeding at ten days postpartum (Bick et al 2012). It was difficult to assess the impact of QI intervention three months later and its impact on physical health even if women were still under midwifery care, although the women in this study were discharged early at around 10 to 14 days post delivery (Bick et al 2012).

The findings of this study suggest the need for early intervention by midwives and promote ways for the betterment of women's health over time. Following the intervention program women reported higher rates of exclusive breastfeeding and fewer problems with physical health (eg urination, mastitis) (Bick et al 2012). Yet, there were no particular differences amongst women in meeting emotional needs during their stay in hospital as well as three months later, after the completion of the EPDS (Bick et al 2012). That might have happened because most women in the study did not consider their emotional health as an important priority in the short time of their stay in the hospital. That contradicts the research of Mac Arthur et al (2002), who found significant differences in mental health outcomes of women 4 and 12 months after the intervention program in the community. However, mental disorders after childbirth are a very important part of maternity care and the need for early diagnosis and intervention is emphasized (Bick et al 2012). Nevertheless, the only interventional study on a global level which had an impact on the mental health of women and talks about the benefits of well planned obstetric care was the trial of Mac Arthur et al (2002).

World Health Organisation (2005) documents suggest that support is necessary for maternal and infant well-being and facilitates women's adaptation to motherhood. Providing support for mothers in caring for their infants in the postnatal period is an important concern for midwives, because social support could aid women's transition to motherhood some of whom find the transition quite stressful (Leahy-Warren et al 2012). Social support, maternal parental self-efficacy (Maternal parental efficacy tool – PMP S-E used) and postnatal depression (EPDS used) aimed to be measured in the study using a descriptive correlational design (Leahy-Warren et al 2012). The final

questionnaire included 16 agreed questions, 4 of which were used to measure each functional dimension. First time mothers with uncomplicated pregnancies were eligible to participate in the study. Although, a convenience sample was used due to time restrictions A randomly selected sample might have given different support needs, maternal parental self-efficacy levels and rates of postnatal depression (Leahy-Warren et al 2012).

Four hundred and ten mothers completed the research measuring instruments mentioned before that were sent at six weeks postpartum. The majority of respondents mentioned friends and family as their main sources of support with fewer participants indicating receiving formal support (health professionals) in infant caring in a six weeks time after delivery (Leahy-Warren et al 2012). The respondents' mothers, partners and sisters were repeatedly acknowledged as the main source of support. Similarly Haslam et al (2006) reported that maternal mothers were the main support mentioned from women as it is likely that they could effectively contribute by sharing their experience and encouraging the woman. On the contrary, higher rates of postnatal depression were measured to mothers who did not have such strong family support (Leahy-Warren et al 2012, Inandi et al 2002). These responses signify the positive influence family support might have over the mother's mental health well being. However, no association was found between professional support and development of postnatal depression.

This is not surprising, since the time spent in hospital was at an average of just over three days (Shaw et al 2006), in a systematic review identified that mothers at high-

risk of postnatal depression would benefit from health professional home visits and peer support. These findings were in agreement with those reported in randomised controlled trials where the intervention was frequent professional support visits (Armstrong et al 1999, MacArthur et al 2002). In the community setting midwives could arrange peer-support group forums and implement practical advices towards infant care. This would help to normalise maternal anxiety, stress and fatigue, mindful of the realities of first-time motherhood and also provide a forum for early detection of postnatal depression (Leahy-Warren et al 2012).

The Australian Government launched the National Perinatal Depression Initiative 2008–09 to 2012–13 as part of maternity services reform in response to the multiple cases of undiagnosed and untreated depression during pregnancy and postpartum (Jones et al 2012). The aim of this five-year initiative was to improve rates of early diagnosis of perinatal depression and enhance the provision of support and treatment for expectant and new mothers (Jones et al 2012). Simultaneously, the Australian National Health and Medical Research Council promoted the establishment of Clinical Practice Guidelines for Depression and Related Disorders in the Perinatal Period (Jones et al 2012). The guidelines developed specify best practice with respect to screening, diagnosis, treatment and management of disorders such as depression, anxiety, bipolar and postpartum psychosis. They also provide specific advice towards marginalised groups (e.g. the culturally and linguistically diverse communities and Aboriginal and Torres Strait Islander communities) (Jones et al 2012).

The midwives were expected to enhance their role by taking on greater responsibility towards the provision of screening, treatment and follow up care of women around childbirth (Jones et al 2012). The position of midwives is unique in providing early assessment of mental health issues and supply relevant information and psychosocial support (Gamble et al 2005). They could also support women in making essential choices concerning treatment (Gamble et al 2005). Essential support requires in depth knowledge and communication skills, as well as the ability of a midwife to process feedback from women and respect their concerns (Homer et al 2009). In order to facilitate any support, it is essential that women are given the opportunity to present their experiences and feelings about childbirth (Jones et al 2012)

In general women express satisfaction with the provision of antenatal care by midwives (Jones et al 2012). In contrast, women in fragmented models of care have expressed dissatisfaction with the provision of emotional care during labour and the post partum (Jones et al 2012). This may be associated with a reluctance of midwives to provide emotional care to distressed women (Gamble and Creedy 2009). Indeed, midwives are generally aware of the importance of emotional support towards women, but they may be apprehensive in case they aggravate women's distress (Gamble and Creedy 2009). This apprehension might reflect midwives' insecurity about their competence to provide emotional support (Gamble et al 2005).

The main aims of the investigation were, therefore: (i) to investigate attitudes of midwives towards caring for women with emotional distress and (ii) midwives' perceptions of the effect workplace policies and processes may have on their support of women with emotional distress (Jones et al 2012). The target group for this study

was 1000 currently practicing midwives, who were members of the Australian College of Midwives. The REASON questionnaire was a 17-item scale, which was originally designed to assess general practitioners and their perceptions regarding the management of patients with mental health disorders (Jones et al 2012). The ability of respondents to evaluate and manage the emotional distress was assessed using the 12-item 'Professional Comfort and Competence' subscale of REASON (Jones et al 2012).

Eight hundred fifteen midwives was the final survey sample. Approximately forty two percent of respondents cited workload as a key factor in the lack of interest towards women with depressive behavior. They also reported that the organizational structure of the work was such that it prevented closer contact with the woman and only focused on current problems of women (Jones et al 2012). However, the majority of midwives reported that they could find time for women with emotional problems and that their involvement with them was not time consuming but in reality it could make a difference (Jones et al 2012). Over half of the participants felt comfortable with providing advice to women with emotional problems. A large proportion said that they felt comfortable discussing mental health issues with women and the midwives did not think it was annoying to ask about them (Jones et al 2012). The majority of respondents indicated that women with anxiety disorders should be referred to a mental health specialist and that midwives themselves could be responsible for this (Jones et al 2012). Although a large number of midwives pointed problems such as workload, time constraints and organizational issues as factors that prohibit them from caring towards women with emotional distress, more than half of the participant midwives reported otherwise (Jones et al 2012).

Quite often midwives have limited contact with women during pregnancy and this does not give them the opportunity for continuous and comprehensive care. Thus, the potential of midwives is not fully exploited especially towards women with mental health problems (Elliot et al 2007). However, in order to provide such care, it might be necessary to create models of care that would take into account midwives' necessary time and resources and the women's need for continuity of care (Elliot et al 2007).

Midwives might find difficult to deal with psychological issues and the heavy workload might prohibit a quality interaction between women and midwives (McLachlan et al 2010). A study using a before and after survey design conducted in Australia which aimed to evaluate an advanced communication skills education programme for midwives caring for women during the postnatal period (McLachlan et al 2010). The education programme used was the so-called PincANEW implemented in Melbourne and involved advanced communication skills (Gunn et al 2006). Twenty five midwives attended the programme of whom twenty two completed the questionnaire before and after the education programme. The participants had to rate items on a four or five Likert scale, and the questionnaires included entries regarding communication skills, willingness to change, learning style and knowledge of and attitudes towards psychological issues (McLachlan et al 2010). The participants stated that after the programme they felt more confident with communication skills and the use of open ended questions, especially when asking about sensitive issues. In addition, midwives were more competent in terms of knowledge regarding psychological issues (McLachlan et al 2010). Midwives found

themselves more proficient to elicit information from women and encourage them to talk about psychological issues. The small sample size was a drawback of the study as there is no information available from the midwives who did not participate in the programme (McLachlan et al 2010). The results support the findings from Gunn et al (2006) where a study of similar context performed. The number of participants was analogous (twenty two out of twenty seven) and the same research design used with the same items for completion in the questionnaire (Gunn et al 2006).

NICE (2007) guidelines are clear on how information to women with an existing mental disorder or women who might develop antenatally or postnatally should be distributed. Health care professionals should develop a trusting relationship with women and culturally sensitive information should be provided in terms of diagnosis or treatment (NICE 2007). Women's ideas, concerns and expectations should be explored by the healthcare providers and regular checks of understanding the information should be implemented. In addition the level of support a woman receives by her social environment and its involvement in woman's care should also be discussed (NICE 2007). Adequate systems should be in place in order to have continuity of care and effective transfer of information (NICE 2007).

4.6 Debriefing

Dyregrov (1989) describes 'debriefing' as a structured intervention in which the participants are asked to outline the events happened and in addition to this describe their feelings and the possible ways it affected their lives. 'Debriefing' is used in the maternity services in order to assess the mother by enabling her to talk about her

birth experiences through structured psychological interventions (Dyregrov 1989). Midwives usually offer debriefing sessions either in the hospital or a home setting within 72 hours of birth (Morrell et al 2009). It is proposed that mothers through the processes of 'debriefing' have the opportunity to talk about their labour and ask information concerning their labour, pregnancy or postnatal period (Smith et al 1996). It is suggested that the extent of psychological trauma from low emotional well-being, to postnatal depression might be caused by their experiences in labour (Axe 2000).

Midwives practising postnatal labour 'debriefing' are in a position of identifying women at risk and giving them the appropriate support or referring them to a specialist (Axe 2000). This is likely to be an effective tool in terms of preventing psychological problems. Smith et al (1996) points out that through 'debriefing' women have the opportunity to clarify events that happened during labour and to answer any queries they have. In addition women can receive further information about future pregnancies or to express their anxieties about their babies (Smith et al 1996). Therefore the midwife is considered to be the most appropriate person to lead this service, because she has the knowledge to answer in the woman's questions and is also aware of problems the woman had throughout her pregnancy and childbirth (Smith et al 1996). This is likely to make the woman feel more relaxed and talk about her birth experience knowing that the other person understands everything. Hence, the woman by sorting out her queries will have a boost in self-esteem and have fewer feelings of disappointment or guilt that she did not perform well during her delivery.

There is a need, however to mention that the effectiveness of ‘debriefing’ is a conflicting topic. Gamble and Creedy (2009) report that the studies of Small et al (2000) and Priest et al (2003) are considered as two of the largest randomized controlled trials regarding debriefing or non-directive counseling as a mean to prevent postnatal depression. Both report that a single session after childbirth will not bring the expected results.

Small et al (2000) conducted a study aiming to examine the effectiveness of ‘debriefing’ in reducing maternal depression after operative delivery. The design was randomised controlled trial and 1041 primiparas having an operative delivery participated in the study. The EPDS and postal questionnaires were used to measure the maternal depression and the overall health status six months after delivery (Small et al 2000). The results showed no difference in the odds of depression between the women allocated to ‘debriefing’ than women who were not. The idea of ‘debriefing’ for most women means that they have to go through a traumatic experience by having to remember all the unpleasant events of childbirth (Raphael et al 1995). The timing of ‘debriefing’ might also not be the appropriate as it may cause a secondary traumatisation rather than helping the person (Robinson 1998). Although it must be mentioned that the person who is performing the ‘debriefing’ should have the ability to communicate with the client, since this plays the most important role in the debriefing process (Robinson 1998).

Priest et al (2003) recruited 1745 women who had deliver term healthy babies (875 as intervention group and 870 as control group) from two large Australian hospitals.

A single debriefing session within 72 hours after delivery was taking place following the principals of critical incident stress debriefing. The aim of the study was to explore whether debriefing could reduce the incidence of postnatal psychological disorders (Priest et al 2003). The results showed no significant difference amongst the intervention and the control group on the EPDS at two, six and twelve months postpartum. Similarly no differences were found on the depression or the duration of depression (Priest et al 2003). It is therefore suggested that a single debriefing session is not of use to prevent postnatal depression (Priest et al 2003).

The conclusions drawn from the above studies are part of the criticism regarding debriefing as a way to prevent postnatal depression. In addition Gamble and Creedy (2009) mentioned that caution should characterise the studies around this topic as the interventions used are not properly described and that makes it difficult for them to replicate for future studies. Another part of criticism is that debriefing is mostly used to prevent postpartum stress disorder rather than postnatal depression (Gamble and Creedy (2009). Further research is, therefore, required in order to have a clear idea about the value of 'debriefing'. In addition further research might give the opportunity to evaluate different 'debriefing' strategies. For example the place, the timing and the person who is going to do the 'debriefing' should be a major concern for better evaluation.

4.7 The role of the obstetrician towards postnatal depression

The role of the obstetrician is very important during pregnancy and afterwards and that has been demonstrated in the literature. Pottinger et al 2009, Flynn, 2009). There contribution in the field of maternity care is of high value as there are in a position to perform interventions (ie Ceasarian Section) that cannot be performed from other health care professionals in the field of maternity (Coleman 2004). However, there is limited information in the literature regarding their role as a whole and even more limited regarding their role towards postnatal depression (Inadi et al 2002, Coleman 2004, Pottinger et al 2009, Flynn et al 2009). The reason might be that most of the research regarding postnatal depression is conducted in countries where midwives have a leading role over the woman's care such as the United Kingdom, Sweden and Australia.

As Pottinger et al (2009) and Flynn et al (2009) mentioned in their studies, the obstetricians should act as one of one of the main contributors in order to identify women at risk and make the appropriate referrals. Coleman (2004) mentions that mental health should be incorporated to the obstetricians' curriculum and that training should be provided in the hospital setting in order for the obstetricians to act appropriately when required.

The limited literature provided for the obstetricians in relation to postnatal depression does not allow the researcher to provide a thorough discussion and offer explanations. However, it is suggested that further research could cover the topic

extensively and especially in health care systems where the obstetricians are the primary care providers throughout pregnancy like the Greek health care system.

Greece lies at the southeastern tip of Europe, at the southernmost edge of the Balkan Peninsula. The country shares borders to the north with Albania, F.Y.R.O.M., Bulgaria and to the east with Turkey, a total length of 1,228 km. The island of Crete in the south lies between Europe and Africa and the Ionian Sea to the west is the border between Greece and Italy (National Statistical Service of Greece 2008). Greece is a country with a population of 11.000.000 million people. The capital of Greece is Athens, which holds a significant number of the country population (4.000.000 million) (National Statistical Service of Greece 2008). The distribution of the population is 58.8% in urban areas, 12.8% in semi-rural and 28.4% in rural areas. The birth rate of Greece comes up to 9.6 per 1000 inhabitants (National Statistical Service of Greece 2008).

4.7 Summary

The chapter included an overview of the mental health illnesses surrounding childbirth and the role of the midwives and obstetricians towards it. The different types of postnatal illness which are distinguished in terms of severity and persistence include 'maternity blues', 'postnatal depression', and 'puerperal psychosis' were mentioned. The severity of postnatal depression and its incidence was discussed.

The literature review has shown that postnatal depression is mostly a social phenomenon, because the majority of the factors influencing it have social roots. The lack of social support, financial hardship and a dysfunctional relationship were identified as the most important social factors. Lack of social support might leave women feeling anxiety, pressure and fatigue. Women, had to cope with both the needs of the newborn and the additional roles they used to perform before childbirth. Therefore, during this difficult period women needed both psychological and instrumental support from their surrounding (e.g. family, friends). Certain groups such as single mothers and teenage mothers have been identified as particularly vulnerable and therefore require special support to overcome the existing difficulties of motherhood.

Previous history of depression was a clear indicative risk factor for postnatal depression. Surveys on the topic have proven that women that suffered postnatal depression were more likely to develop it again in a following pregnancy (Cooper et al 1995, 1996). A major topic of argument was the hormonal changes that could happen during pregnancy and their effect on postnatal depression. No significant difference related to hormonal changes was found between women with postnatal depression and women without. However, thyroid dysfunction was a hormonal factor related with an increased risk of development of postnatal depression.

Postnatal depression is not just a maternal problem, but a family problem. Besides its effects on the partners, a major issue was the detrimental effect that the mother's

depression can have on the child's social and intellectual development. More attention should be, therefore, given not only to the woman's emotional state, but how this state could affect her relationships.

The importance of the role of the midwife and her relationship with the woman was strongly mentioned throughout the literature review. The way women experienced the three stages of childbirth antenatal, natal, postnatal and what they sought from their midwives in order to tackle postnatal depression has also been investigated. The need for further information and better communication with the midwife was the primary concern for most women during the antenatal period.

The role of the obstetricians was finally discussed. Its importance was clear in the literature. However, limited research of obstetricians in conjunction to postnatal depression did not allow a substantial amount of work. Hence, further research is required in order to obtain as much information as possible within this area.

5 METHODOLOGY

This chapter presents a detailed justification of the methodological choices that underline the particular research project. It outlines the process of determining a specific and focused research question as well as all the theoretical and methodological assumptions surrounding it. In doing so, the researcher endeavoured to give the reader a clear picture about the research project and the issues arising during undertaking this research. This presentation has, moreover, given the researcher herself an opportunity to reflect on the journey of accomplishing this study.

5.1 Introduction

This chapter will give:

- The aims of the study
- The research design
- The research process

Aims of the research

The main aim of the study is to explore the quality of maternity care regarding postnatal depression in the North West region of Epirus in Greece.

Objectives

1. To explore the perceptions of midwives and obstetricians on postnatal depression.
2. To understand midwives' and obstetricians' views on the adequacy of current health care settings in dealing with postnatal depression.
3. To obtain midwives' and obstetricians' suggestions on the improvement of care in relation to postnatal depression.

5.2 Theoretical framework

Harper and Hartman (1997) suggest that beliefs, values and past experience help individuals construct personal philosophies about how the world is constructed. These philosophical views of the world, or otherwise known as paradigms, are expected to influence the way health care is both provided and received (Lincoln and Guba 1985). This is because the actions of individuals in the world are a result of the paradigms they have formulated and which act as an influence on their actions (Lincoln and Guba 1985).

Denzin and Lincoln (2000) suggested that the positivist and naturalistic paradigms are the two major paradigms involved in most of the research inquires. Traditionally, the positivist paradigm is associated with quantitative research and the naturalistic with qualitative research. The major assumptions of these paradigms are presented in the table below.

Positivistic paradigm	Naturalistic paradigm
<p>Argues for the existence of ‘objective’ reality that can be measured and will be the same for all observers</p> <p>Measures the relationship between measurable variables the causal relationship between events</p> <p>Can be context free</p> <p>Objective</p> <p>Might be a fixed structure</p> <p>Based on the principle of empirical testing or development of pre-existing theory</p> <p>Deductive approach</p> <p>Researcher is an ‘objective’ observer of events</p> <p>Aim to achieve representative data on pre-determined and adequate size population samples</p> <p>Measures include standardised questionnaires and observation of</p>	<p>Reality is a construction of the individual – and is not objectively ‘observable’</p> <p>Explores the subjective experience of individuals, focusing on the meaning of the experience from the individual’s perspective</p> <p>Is not context free, but is determined by the context and setting.</p> <p>Subjective</p> <p>Flexible structure</p> <p>Can be used to generate new theory</p> <p>Inductive reasoning</p> <p>Researcher is an interpreter of events, which may be influenced by their own subjective state</p> <p>Usually collect data until saturation is reached</p> <p>Measures include interviews and observation</p>

behaviour	
Statistical analysis	Thematic analysis. Searching for patterns and themes within text

Table 1: Research paradigms (Information from Holloway and Wheeler, 1996, Morse and Field, 1996, Denzin and Lincoln 2000, Silverman 2000)

The method selected for any particular study should be the most appropriate for answering the research question (Morse et al 2001). Either approach may be used independently of the other, or combined, depending on the focus of the question (Silverman 1997, Strauss and Corbin 1990). Thus, these two research approaches should not be viewed in isolation, but as complimentary to each other, approaching research from different, but equally valid perspectives. Because of the nature of the research questioned posed in the beginning of this chapter, this research project adopts a qualitative approach to data collection and analysis.

5.3 Research design

5.3.1 Qualitative inductive research approach

Historically, healthcare research has been predominantly quantitative in approach (Morse et al 2001). In contemporary healthcare, however, there is increasing emphasis on the need to consider the views of patients and carers within their own environment and cultural context. This is because it is understood that the perceptions of healthcare differ among individuals and settings i.e. country, hospital,

city etc (Leininger 1996). Hence, research areas such as these are often approached from a qualitative perspective. (Morse et al 2001).

Qualitative research aims to gain an in depth understanding of the phenomenon under study as it exists in the real world and as it is constructed by individuals within it (Denzin and Lincoln 2000). It seeks to capture people's perceptions [emic perspective] as they develop through their own reality and the meaning they attach to it (Miles and Huberman 1994).

David Silverman (2000) and Janice Morse (2001), propose a similar context in their understanding of qualitative research by stating a preference to the naturally occurring data and the understanding of the world through words. Therefore, emphasis is given to the importance of the people's point of view and their own opinion and understanding of a particular phenomenon.

Several methods are proposed to capture the emic perspective. Field notes, interviews, conversations, photographs, recordings, memos are some of these ways as these were suggested by some major thinkers of the qualitative paradigm (Denzin and Lincoln 2000, Miles and Huberman 1994, Lincoln and Guba 1985, Hammersley and Atkinson 1995). It is believed that in this way there is a continuous commitment to events, actions or thoughts from the perspective of those being studied (Bryman 2001). It also allows the researcher to immerse himself into the setting and the

situation of participants and understand how they perceive their world and how cultural, social and other factors affect their actions (Cormack 2000, Parahoo 1997).

Therefore, the interactive process in qualitative research empowers both respondents and researchers. Respondents by expressing their needs, views and experiences, have their voices heard, which helps to provide better care. The interactive relationship allows the researcher to obtain valuable data about respondents' experiences, which empowers the researcher (Parahoo, 1997).

However, this interactive nature of qualitative research has been criticised as a weakness of this research approach. Sandelowski (1986) suggests that close involvement with participants might lead to an inability by researchers to separate their experiences from those of respondents. In addition, the influence of the researcher on that data collected is also considered as a major drawback (Silverman 2000).

In order to overcome the critique over qualitative research Lincoln and Guba (1985) suggested ways to obtain trustworthiness. Even so, the aim of the qualitative research is to have a 'thick description' of a particular setting at a particular time rather than offer a generalization of the findings. This is a major topic and going to be discussed thoroughly in the following sections.

The current study was undertaken to explore ‘the quality of maternity care in relation to postnatal depression’, and to understand and explain the perceptions and suggestions of the people surround it. The researcher acknowledges that people of each culture differ in the way they experience and perceive the concept of health care. Moreover, they relate it to their general health practices and beliefs (Helman 2000). The study could be influenced by health care providers and women’s values, beliefs, culture, background, social context and social interaction. Therefore, this study was clearly not harmonious with a quantitative approach. The issue of postnatal depression was previously unexplored in Greece and therefore, in order to explore the quality of maternity care in relation to postnatal depression, a qualitative approach was required to gain an in depth understanding. Based on these premises, the study draws from the ethnographic approach in order to answer the research questions. A rationale to using this approach is given in the following section.

5.3.2 Ethnography

Ethnography derives from the Greek term *ethnos* and *graphi*. *Ethnos* means a nation, a race or a cultural group. *Graphi* means representation or interpretation of observations of objects or events. In combination the two terms signify the in depth understanding of the variability of human existence (Denzin and Lincoln 2000). Hammersley and Atkinson (1995) describe ethnography as involving:

“...the ethnographer participating, overtly or covertly, in people’s daily lives for an extended period of time, watching what happens, listening to what is said, asking questions – in fact, collecting whatever data are available to throw light on the issues that are the focus of the research.”

(Hammersley and Atkinson 1995)

Thus, the present study is trying to get an in depth understanding of the midwives, doctors and women's views, beliefs and practice in their natural setting and to collect naturally occurring data. Ethnography according to Hammersley (1990) follows a number of features which are:

1. People's behavior is studied in everyday contexts, rather than under experimental conditions created by the researcher.
2. Data are gathered from a range of sources, but observation and /or relatively informal conversations are usually the main ones.
3. The approach to the data collection is 'unstructured' in the sense that it does not involve following through a detailed plan set-up at the beginning; nor are the categories used for interpreting what people say and do pre-given or fixed. This does not mean that the research is unsystematic; simply that initially the data are collected in as a row a form, and on as wide a front, as feasible
4. The focus is usually a single setting or group, of relatively small scale. In life history research the focus may even be a single individual.
5. The analysis of the data involves interpretation of the meanings and functions of human actions and mainly takes the form of verbal descriptions and explanations, with quantification and statistical analysis playing a subordinate role at most.

(Hammersley 1990)

These features are in accordance to the proposed design of this project. The informants in this project were located in a hospital and there was everyday communication with each other. Field notes were kept of everyday communication

and observations made. Data were gathered from observation, conversations and interviews. Data collection was relatively unstructured, although interviews had a semi-structured approach. The focus was the obstetrics department and more specifically midwives, obstetricians and women; and these are the people who are directly involved with the specific services. Analysis attempted to explore the perceptions of the study group regarding postnatal depression as well as the adequacy of the setting and their suggestions on improvements.

In ethnography, analysis is a continuous process that begins with the pre-field work and continues throughout the process until the writing up of the final report. Although, it is formally written in analytical notes, it always informally exists in the researchers' ideas. Therefore, it is incorporated in the study from the initial steps 'feeding' the research design and data collection (Hammersley and Atkinson 1995). The researcher felt that a qualitative exploratory ethnographic research approach would give her the chance of getting closer to the informants and would therefore have the potential to obtain a great deal of in-depth information. However, there were several issues to think about before even entering the actual field work such ethical considerations and confidentiality and anonymity issues.

5.4 Ethical considerations

The declaration of Helsinki, (WHO and CIOMS 1989) stated that in any research where human beings are involved, each potential subject must be adequately informed of the aims, methods, anticipated benefits and potential hazards of the study and the discomfort. This view is supported by Hammersley and Atkinson

(1995), as well as Denzin and Lincoln (2000) and David Silverman, (2000) which they all consider it as a key element in the rigour of a study.

Before collecting the data, approval to conduct the study was obtained from the Scientific Committee of the University Hospital and the chairperson of the Maternity Services.

Permission to observe the settings was granted after contacting the appropriate gatekeepers, in this case the consultant of the Obstetrics and Gynaecology Department and the sisters of each Ward, meaning the delivery suite, the postnatal ward and the antenatal clinic.

5.4.1 Informed consent

The provisions of both European and UK law as in the Data Protection Act (1998) and ethical guidelines of academic research organisations recommend the following minimum requirements:

- consent must be freely given with enough detail to indicate what has been agreed
- there must be active communication between the parties - what is expected from participants and why their participation is required
- documentation outlining consent has to differentiate between consent to participate and consent to allow findings to be shared or published
- consent cannot be inferred from a non-response to a communication such as a letter or invitation to participate

(Data Protection Act 1998, Chapter 29)

Therefore, the researcher tried to comply with the above requirements. The researcher wrote an informed consent letter where the scope of the study was briefly but clearly outlined as well as their rights as participants. The researcher ensured that participants were engaging voluntarily, without coercion and in the knowledge they could withdraw at any time, as this is a fundamental ethical principle of research (Denzin and Lincoln 2000). Participants were also ensured that they could feel confident that there will be no adverse consequences of their involvement in the research. They were also assured that they need to respond only to questions they felt comfortable with and that there is no wrong or right answer. The participants had the right to refuse the use of the tape-recorder. In such case the researcher would use field notes only (Kvale 1996). The respondents had to read it carefully and signed it in addition to a consent letter that they were willing to participate in the study.

However, as Punch (1986) argues, it is very difficult in ethnographic studies to obtain consent from everyone who is going to be involved in an observation scene. This is because ethnographers carry out research in natural settings and that in large organisations such as hospitals there is a constant engagement and interaction with various people (Hammersley and Atkinson 1995). Hence, in this research project, as it involves overt participation, the researcher obtained consent from the staff but not from the patients or any other third party involved in the scene.

5.4.2 Confidentiality and anonymity

Most research will include sensitive or confidential information. This issue must also be dealt with as part of the process of gaining informed consent. Ways of dealing with confidentiality vary widely depending upon the research project in question, often the main concern is with the disclosure of names, addresses and sometimes occupational and locational details (Denzin and Lincoln 2000).

The researcher assured the participants that confidentiality and anonymity were guaranteed. ID numbers and pseudonyms were used in order to provide anonymity to the respondents. The researcher tried to achieve confidentiality by reassuring the respondents that nobody else would have access to the data and be able to match the real identity with the ID numbers apart from the researcher herself. Additionally, any personal characteristics would be avoided for people not to be recognised by their profile. Also, the transcripts and tapes were used only by the researcher. At the end of the project, the tapes will be kept for fifteen years in case it needs revisiting and afterwards they will be destroyed and no stored data would be given to anyone else.

However, access to the data was granted at any time, if the participants felt any kind of deception over their given information (Denzin and Lincoln 2000). Lincoln and Guba (1989) suggest that informants should have the right to control information related to them and its potential use. Although, there is always a possibility involved that some informants might wish to make changes to their information (Hammersley

and Atkinson 1995). Therefore, the researcher made clear that the data would be used for academic purposes and the results of the study could be published.

In addition for the researcher to ensure complete confidentiality, the name of the hospital would not be revealed, unless the hospital authorities permit it. However, because it is the biggest hospital in the North West region of Greece, it might be difficult not to be recognised. This brings up the issue of ‘harm’ as Hammersley and Atkinson (1995) acknowledge.

5.4.3 Beneficence and nonmaleficence

The concepts of beneficence and nonmaleficence are closely linked and subject to many interpretations (American Psychological Association 2003). As with professional codes of conduct, the researcher has an obligation to protect the rights and welfare of those involved in research. This means that the participants should not experience any harm as a result of that research regarding their physical, emotional or social well-being (American Psychological Association 2003).

In the present study the researcher should acknowledge the fact that the aim of an interview is to extract information and not to establish a therapeutic relation with any sensitive informant e. g. women suffering with postnatal depression (Kvale 1996). Thus, Kvale (1996) proposes that if the researcher foresees a potential need for therapy following research interviews, back-up arrangements with a therapist might

provide a solution. The researcher finds it unethical not to offer this alternative, if there is a need to do so.

Although ethnographic research involves less damage than other types of research, consequences might also arise as a result of the actual research process or through publication of the findings (Hammersley and Atkinson 1995). Especially when large organisations are involved, like hospitals in this case, many people have different opinions about the concept of care or the relationship between the staff and the clients. Therefore, the researcher should be very careful when addressing such issues. Hence, the researcher should be very clear about the aims of the project and to which purpose the data obtained will be used, as well as ensuring that all the methodological steps are clearly followed.

5.5 The research sample and sample size

Morse and Field (1996) suggest two principles that guide qualitative sampling: appropriateness and adequacy. Participants should be able to inform the purpose of the study as determined by the research question and stage of the research, and should provide enough data to develop a full and rich description of the phenomenon (Morse and Field 1996, Spradley 1979). If these criteria are not met, qualitative results are thin and the trustworthiness of the study is threatened (Morse and Field, 1996).

In a critical analysis of purposive sampling, Patton (2001) identified sixteen types of sampling in qualitative research, and there are others not included. Patton (2001) concluded that, despite the different language used to define variations of sampling, all sampling in qualitative research is purposeful sampling, in that it is conducted with a purpose.

Kvale (1996), Hammersley and Atkinson (1995) as well as Spradley (1979) emphasise the notion of locating ‘a good informant’, which will give a rich description of the phenomenon under study. In this study, sampling decisions were made at two levels. Initially, a decision had to be made about the group to be studied. A second decision was made after a group selected for the study had withdrawn. Originally, women who had suffered with postnatal depression were included and midwives and obstetricians who were working for the particular hospital.

The University Hospital where the study conducted serves the Northwest region of Greece and disposes a number of seven hundred and fifty beds. The annual rate of deliveries reaches one thousand and five hundred (National Statistical Service at Greece 2008). Midwives and obstetricians were required to have at least two years of working experience either in the antenatal clinic, or the postnatal ward or the labour ward of the particular hospital, which makes them according to Spradley (1979), ‘enculturated informants’. This might enable them to give thorough insights of the particular setting in order to gain more accurate information. No other criteria applied in terms of gender, background or age. The informants had a mixture of

varied qualifications and experience, as is the case in any similar setting. The health care providers were recruited after contacting the Head of each group respectively in the particular hospital.

Women taking part in the study were women who suffered postnatal depression after their latest pregnancy. These women had to have been clinically diagnosed with postnatal depression and were fully recovered. These women had to have delivered in the particular hospital during the previous four years until approximately the end of 2003. This was to ensure that women, who had given birth recently and may currently suffer with postnatal depression, were excluded. Women who suffered with postnatal depression more than four years ago were also excluded as they might have forgotten several parts of their pregnancy and the care provided. There were no inclusion or exclusion criteria in terms of parity, age, nationality, or the type of delivery. However, women that had serious obstetric complications during pregnancy and were hospitalised for a long period of time were excluded.

The primary selection of informants was going to be made by the outpatients department of the Psychiatric Unit of the hospital. However, the gatekeepers were hesitant to reveal the names of their patients. Therefore, a secondary selection of participants was used according to Morse (1996) and Denzin and Lincoln (1998). In case a similar problem arises, they recommend advertising as a solution to the problem (Morse 1991, Denzin and Lincoln 1998). Therefore, the researcher

advertised it in the local newspaper and nursery schools to enable her to recruit participants fitting the criteria posed above.

Patton (2001) refers to the sample size as the number of participants necessary to reach data saturation. And the number of participants depends on the purpose of the study, what the researcher wants to know, what is useful and credible and the resources and time available. Lincoln and Guba (1985) recommend redundancy as a sample selection criterion.

Though, as practical problems might arise when no idea of sample size is given, Patton (2001) suggests, that a minimum sample should be recommended. Therefore, in the current study a minimum sample of thirty participants was the intended target to be recruited, with ten participants for each group respectively. The hospital employs twenty five midwives and fifteen obstetricians. Out of the twenty five midwives twenty were fitting to the inclusion criteria. From the remaining twenty, three refused to be interviewed for personal reasons. Obstetricians were all fitting the criteria, however, five refused to participate for personal reasons. Hence, ten obstetricians and seventeen midwives were recruited. This makes a heterogeneous sample which might provide in-depth information and demonstrate both a variety and commonality of experiences. Following Lincoln and Guba (1989), after saturation of the data, meaning that no new information was coming up, the researcher stopped recruiting any additional informants. The researcher, following the advertisement technique, managed to recruit five women. Given that this is an exploratory study,

the researcher wanted to ensure that she had included ‘information-rich cases and describe the current status of the care provided.

A while after their interview was completed, three women wanted to withdraw from the study for personal reasons. This left the researcher with two women only. This was a very small number to be considered as part of the data analysis process. after extensive discussion with her supervisors, a decision was made not to include them in the study.

The study clearly has limited generalisability considering the small sample size and the context of the study. For example, all participants were selected from the same hospital. However, the goal of a qualitative inquiry is to understand rather than generalise (Denzin and Lincoln 2000). Hence, the inclusion of all possible participants offers a fairly representative sample of the population of the area of study.

5.6 Reflexivity

Naturalistic inquiry emphasises the importance of going into the field and being close to the people and situations being studied. Social researchers are part of the social world that they study and this is a way of having direct contact with people, their own environment and personally understand the realities of a situation

(Hammersley and Atkinson 1995, Davis 1999, Finlay and Gough 2003). Triandis (1994) from his perspective as a psychologist has a similar view. He considers that getting into the field where people live and examining related issues such as socialisation, are essential for gaining understanding of specific situations and people's actions within them.

Personal contact is something that has been demonstrated in several studies as well as the proximity and closeness to the people or situations being studied (Patton 1990). These include Freud's proximity to his patients, Darwin's closeness to nature, Piaget's closeness to his children and Shapiro's personal encounter with young children in classrooms (Patton 1990). This personal contact is frequently criticized for its inherent subjectivity, but it is the only way to discover important insights and crucial differences that allow the researcher to evaluate a situation in a meaningful and relevant way. Therefore, issues of subjectivity must be addressed as part of the process. However, as Davis (1999) states, it depends on the extent and nature of the connection that questions the researcher's influence upon the results obtained.

Similarly, Hammersley and Atkinson (1995) discuss that every researcher goes to the field with theoretical presuppositions and affected to a certain extent by his/hers cultural beliefs. It is argued though that is inevitable to abolish a human being's beliefs and values (Triandis 1994). This implies that each and every individual has a fixed set of preconceptions about the world which, affect his/hers way of thinking.

An awareness of the influence of these experiences is vital to the researcher when trying to interpret and understand other people's opinions and perceptions.

Researchers especially within the qualitative tradition seek to demonstrate the trustworthiness of their findings. Thus, reflexivity offers an opportunity for the 'subjectivity to be transformed from a problem to an opportunity' (Finlay and Gough 2003). Davis (1999) argues that reflexivity is a way of looking at oneself, to identify ones own personal and professional practices.

However, this is a definition similar to other researchers' like Hammersley and Atkinson (1995). Finlay and Gough (2003) make a clearer distinction between its etymology and research meaning. 'Turning back on oneself', is the etymological root of the word 'reflexive' (Finlay and Gough 2003). In research terms this can be translated as 'thoughtful, self-aware analysis of the intersubjective dynamics' between the researcher and the researched (Finlay and Gough 2003). Thus reflexivity requires a continuum of self-reflection in order to identify all the researcher's assumptions, social background and behaviour that may impact upon the research process.

Taylor et al (1999) emphasizes to the social researchers the issue of analysis and interpretation of findings by saying that the findings in social researcher are usually coloured by the researchers' social background, experiences and culture. What a researcher sees and how he/she interprets it will be influenced by the fact that the

researcher is a member of the social world. Social research is interactive and to some extent those being studied are influenced by the presence of the researcher. This is not necessarily negative but it can be a positive point for the inquiry without dramatically affecting the validity of the study (Hammersley and Atkinson 1995). They suggest that the researcher should not only minimize or monitor the reactivity but also exploit it. Any kind of interaction either positive or negative or even absence could be an important part of the data, rather than being ignored as an insufficient research product (Schuman 1982, cited in: Hammersley and Atkinson 1995). Rather than seeking thus to reduce the importance of the reflective interaction which occurs in an interview situation for instance, it is better to recognize and apply the knowledge gained from that. This recognition might mean that the researcher was critical to himself/herself, to the research and to the findings. The researcher should be able to examine the extent to which the findings might reflect his own beliefs and values.

Finlay and Gough (2003), use the term 'critical self-reflection', in an attempt to capture both sides of the reflection and reflexivity. The distinct nature of these concepts must be acknowledged by the researcher in order to construct valid results and a real picture of the study context. In social research and particularly in qualitative inquiry where the concepts of reflexivity and reflection are heavily involved, the contribution of both concepts in the construction of new knowledge should not be undermined by the notions of objectivity and invalidity of the results. Both reflexivity and reflection are valued throughout the stages of the present study as an alternative method to provide knowledge that cannot be adequately provided by

the use of other methods. In terms of subjectivity and credibility of the results, the researcher must question whether his presence affects the actions or the responses of those involved in the study.

The researcher enters the field without any predetermined conclusions or pre-conceived ideas about the subject under investigation. In other words without being biased in terms of what he/she expected to find in a certain investigation. However, the elimination of subjectivity in naturalistic inquiry may not only be impossible but also undesirable. Davis (1999) suggests that in qualitative inquiry the researcher's bias cannot be eliminated, it could however, be identified and examined in terms of its impact on data collection process and interpretation. Kvale (1996) commenting about the interview situation in particular, states that the researcher should be conscious of the interpersonal dynamics within the interaction and take them into account in the interview situation and in the analysis later on. Reflexivity as suggested by Finlay and Gough (2003) is a process which involves self-examination while the researcher examines his/her own perspectives and determines how this perspective has influenced not only what is learned but also how it is learned. Keeping a personal diary or employing a method of noting personal feelings, attitudes, reactions and obstacles in each step of the data collection process is referred to as a critical aspect in identifying and examining the researcher's personal influence on the data collection and interpretation (Hammersley and Atkinson 1995).

Lincoln and Guba (1985) refer to another way to increase rigor in naturalistic inquiry. This is the maintenance of an 'audit trail' as the researcher proceeds analytically. In this approach the researcher is responsible not only for reporting results but also for explaining how the results were obtained. An 'audit trail' was developed through a structure, which has shown the initial design of each stage, the knowledge derived and how limitations created a way for alternative considerations, which in return provided new insights and knowledge. By explaining the thinking and process of an inquiry, the researcher allows the readers to follow the logic and manners of the research process and confirm or reject the interpretation.

The concept of 'going native' is something that the researcher should also take into account. This concept indicates that the researcher has spent an extensive period in the field and there is a danger of blending with the informants and might begin to share the assumptions of the participants (Davis 1999).

As Davis (1999) suggests, the concept of 'going native' should make the researcher critically think about it otherwise it might prove problematic. The researcher should think how to maintain a 'distance' without losing authenticity. Narayan (1993, cited in Davis 1999) comments that it is difficult to meet someone who is completely unreflective and is a complete insider in any situation or setting. Hence, it is expected that the ethnographic researcher, in particular, should find themselves detached even from the most familiar and inclusive groups. The researcher of this study being away

for an extensive period of time allowed herself to detach from her culture and not take everything for granted.

However, as a person the researcher here viewed the informants as a midwife, as a researcher, a Greek and from the same city. Reflection was used to identify her own preconceptions and expectations about the research process. Attention was given to the interaction between the participants feelings, opinions and perceptions and the researcher's personal perspective. This might insure that the interpretation reflected a stance of neutrality with regard to the participants' actions and statements during the fieldwork period whilst acknowledging where I come from. Therefore, a sufficient time away from the field is recommended to allow time for reflexivity (Hammersley and Atkinson 1995).

5.7 Data collection methods

Denzin and Lincoln (2000) suggest that triangulation of data collection methods is one way to generate rigour. The researcher used observation and semi-structured interviews with the aim of answering her research questions.

5.7.1 Observation

Lincoln and Guba (1985) suggest that observation allows the researcher to reveal unconscious behaviours and customs as well as permits the researcher to fully interact with the participants and be part of their own culture. Thus, the researcher was going to be an 'observer as participant' according to Gold's (1958) distinguish between the 'complete participant', 'participant as observer', 'observer as participant' and 'complete observer'. Although there is a fine line of distinction between the two middle ones (Hammersley and Atkinson 1995), the researcher adopted the suggested role. This is because the researcher was not going to be part of any working team; however, she would be present by location only. The researcher wished to observe the working environment where the maternity care was taking place including the antenatal clinic, the maternity ward and the labour ward.

The observation was going to be descriptive initially, becoming more focused at the end, following Spradley's (1980) ethnographic research cycle. Primarily, the researcher would give a full and detailed description of the layout of the settings where care was taking place. Architectural plans might tell us about how patients' needs were perceived. Gradually, the researcher focused on how the participants acted and interacted within these particular settings revealing probable aspects of tacit knowledge that might influence the care given. The observation focused on aspects like the policies and practices of the three clinics, the responsibilities of the care providers, the time dedicated to a woman, the waiting list in the antenatal clinic, the information given to women and aspects of psychological support towards them.

Nevertheless, as Spradley (1980), Hammersley and Atkinson (1995) and Fetterman (1989) suggest, the researcher might become more selective during fieldwork as new or interesting concepts relevant to the topic might arise. However, the researcher built trusted relationships in the field, as there was always the danger that the participants might have reacted very carefully at the beginning, being aware of her presence. As part of training process the researcher did some observational sessions which helped her to reflect on the on-going process.

5.7.2 Interviews

Interviews in ethnographic research might range from spontaneous informal conversations to formally arranged ones (Hammersley and Atkinson 1995). They could be very useful in order to generate data that it might have been difficult to obtain otherwise e.g. events described or perspectives about the topic (Hammersley and Atkinson 1995). In the current study, the researcher used formal semi-structured interviews, which although were organised to a certain degree, still offered the flexibility to the participants to express their own perceptions on the phenomenon under study (Denzin and Lincoln 2000). However, ethnographers, although they would enter the interview with a range of topics to be covered, they might not decide in advance detailed questions they want to ask or the questioning amongst interviewees might be slightly different (Hammersley and Atkinson 1995). Hence, the researcher attempted to elicit more information about the participants' views towards postnatal depression and the care provided. Specifically, the researcher questioned demographic characteristics, aspects of the antenatal routine

examinations, the decision making process and the psychological support given throughout pregnancy, during labour and the maternity ward afterwards.

As Kvale (1996) suggests, the aspects of context that may potentially affect any interaction are infinite. Some elements of context have been identified as the time of day, the actual research setting, the mood, presence or absence of other persons, seating arrangements, the appearance and dress of the researcher, the way in which questions are worded, non-verbal behaviour, interruptions and other occurrences, the researcher's attitude or tone of voice, or even the way in which participants are greeted by the researcher at the start of the interview (Kvale 1996, Spradley 1979).

However, this should not be viewed as problematic in qualitative research providing all the factors that might influence a study are fully acknowledged. Another potential problem is the fact that when the researcher is a care provider as well, this might raise concerns about issues such as interviewer bias, respondents seeking to please the researcher and inequality in relation to power and status. Therefore, the researcher should critically reflect on this dual midwife/researcher role before and after conducting an interview. The researcher tape-recorded the interviews. The researcher predicted that a time frame of 3 to 6 months was needed to collect the data.

5.8 Establishing trustworthiness

One of the biggest challenges a researcher has to face is to prove that all methods used were as reliable and accurate as possible (Lincoln and Guba 1985). The debate centres on the reliability of the qualitative versus quantitative approach (Denzin and Lincoln 2000). The trustworthiness of the qualitative approach has been challenged many times over the years (Denzin and Lincoln 2000). Thinkers from the positivist paradigm always felt proud about the validity and reliability of their research methods and how accurate they were (Hammersley 1992). The answer given by the qualitative thinkers is that naturalistic enquiry takes part within a social context and there are no means by which you could accurately measure it (Hammersley 1992, Silverman 2000). However, there should always be certain criteria in place to ensure the validity and reliability of every research project irrespective of its nature.

However, there is another debate amongst qualitative thinkers concerning the issues of validity and reliability. Hammersley and Atkinson (1995) approach is what he calls 'subtle realism'. From a realist point of view they argue that there is a reality independent of our knowledge of it (Hammersley and Atkinson 1995). On the other hand he claims that we could only know reality from our own perspective in it (Hammersley and Atkinson 1995). Thus, qualitative and quantitative researchers should be more focused on representing the reality rather than achieving the *truth* (Mays and Pope 2000). Silverman (2000) uses a similar notion and proposes the use of the words validity and reliability in order to evaluate qualitative research. He

proposes a number of different criteria in order to validate qualitative research such as careful case selection, ongoing hypothesis testing, and inductive analysis (Silverman 2000). He also suggests that reliability could be achieved by using standardised methods of taking field notes and transcribing the data and by using peer review during data analysis (Silverman 2000).

Lincoln and Guba (1985) similarly argue that to establish trustworthiness one has to look into concepts deriving from conventional validity and reliability. They believe that there are four questions asked according to the conventional paradigm in order to establish trustworthiness.

1. Truth value: How can one establish confidence in the ‘truth’ of the findings for the subjects of a particular inquiry in the context in which the inquiry was carried out?
2. Applicability: How can one determine the extent to which the findings of a particular inquiry have applicability in order contexts or with other subjects (respondents)?
3. Consistency: How can one determine whether the findings of an inquiry would be repeated if the inquiry were replicated with the same (or similar) subjects (respondents) in the same (or similar) context?
4. Neutrality: How can one establish the degree to which the findings of an inquiry are determined by the subjects (respondents) and conditions of the inquiry and not by the biases, motivations, interests, or perspectives of the inquirer?

(Lincoln and Guba 1985 p:290)

Conversely, supporters of the antirealist position argue that naturalistic inquiry is a research paradigm on its own and therefore, qualitative research as such, cannot be judged by conventional measures of validity, generalisability, and reliability (Lincoln and Guba 1985). Instead, they propose their own four criteria to replace the conventional approach criteria and techniques to establish trustworthiness (Lincoln and Guba 1985). Below is a summary of those criteria and techniques.

Criterion Area	Technique
Credibility	1) activities in the field that increase the probability of high credibility
	a) prolonged engagement
	b) persistent observation
	c) triangulation (sources, methods, and investigators)
Transferability	2) peer debriefing
Dependability	3) negative case analysis
	4) referential adequacy
Confirmability	5) member checks (in process and terminal)
	6) Tick description
All of the above	7a) the dependability audit, including the audit trail
	7b) the confirmability audit, including the audit trail
	8) the reflexive journal

Table 2: Summary of the Techniques for Establishing Trustworthiness (Lincoln and Guba 1985, p:328)

The point was to replace ‘truth value’ (or internal validity) with credibility, applicability (or external validity) with transferability, consistency (or reliability) with dependability and finally, neutrality (or objectivity) with confirmability (Lincoln and Guba 1985). The particular research inquiry is drawn upon a qualitative perspective and therefore complies within the naturalistic paradigm. As discussed

above, although there are various opinions on the criteria establishing trustworthiness, the researcher will follow the Lincoln and Guba's (1985) criteria. The researcher feels that Lincoln and Guba's (1985) criteria and methods are focused and by following them one by one it might help to establish trustworthiness.

5.8.1 Credibility

One of the key questions on any research project is how compatible the findings are with reality. So, it is of primary importance to ensure that all the above criteria are met. Thus, the researcher has to ensure that answers were given to the four methodological questions posed earlier by Lincoln and Guba (1985). Therefore, the researcher has to accurately describe and interpret their experience in order to achieve credibility. The following provisions were made by the researcher to promote confidence in the accuracy of the recorded phenomena under study.

The choice of methods used for data collection and data analysis are of primary importance and is essential to prove that they were the right ones used for the particular inquiry (Mays and Pope 2000). For that reason the researcher gives detailed accounts of the specific methodology used and why, as well as data collection methods and analysis. The influences from other researchers and similar projects are also described at the beginning of the chapter. However, it is very important not to only describe the final choices of the research project but to demonstrate how they developed throughout the project and what influenced them (Denzin and Lincoln 2000). A field journal was kept for that reason, in which the

content and the process of interactions were noted, including reactions to various events. Koch (2006) also finds that it is necessary to keep a field journal in order to increase self-awareness of the researcher which she considers essential. It proved to be very useful to record the research progress and provided material for reflection throughout the study.

Lincoln and Guba (1985), recommend 'prolonged engagement' as a way of familiarizing with the 'culture' under scrutiny before the first data collection dialogues take place. That might help the researcher to gain an adequate understanding of the organization and to establish a trusting relationship with the informants (Hammersley and Atkinson 1995). This might be achieved by visiting the setting prior to the investigation and consulting appropriate documents (Shenton 2004). The researcher should not be discouraged by potential obstacles like 'suspicious' gatekeepers and staff (Silverman 2000). It might be difficult for people to understand the concept of research in general and not to act accordingly at the beginning. However, the other end of 'going native' should be avoided as much as possible with the danger of overbuilding rapport and over familiarity with the setting (Davis 1999). That might result in the researcher losing focus and not achieving the personal distance required. There is no set time as to how long 'prolonged engagement' should take. As Lincoln and Guba (1985) specify, 'long enough to be able to survive without challenge while existing in that culture'. The researcher of this project has spent one month prior to the main research introducing herself, making contacts with the gatekeepers, making herself known to the staff and familiarizing herself with the setting. A detailed account of access in the field is

given in a separate section. The researcher also provides her thoughts in ‘going native’ and how she tried to minimize it.

‘Persistent observation’ is another technique to achieve credibility (Lincoln and Guba 1985). In contrast with ‘prolonged engagement’, its purpose is ‘to identify those characteristics and elements in the situation that are the most relevant to the problem or issue being pursued and focusing on them in detail’ (Lincoln and Guba 1985, p:304). The researcher used her pilot study in order to identify key themes and narrow down her observational foci. A thorough description of this process was required in order for the author to give all the details of this process. On the other hand, there is always the danger that the researcher might come to a focus too soon. This might be a result of pressure from clients or seniors which could affect the results credibility (Silverman 2000). Therefore, the researcher should take the time needed and not allow these kinds of situations to interfere with the inquiry. However, as far as observations are concerned, there might always be something new emerging and deserving attention. Detailed accounts are presented in the observations session and the data analysis chapter.

5.8.2 Triangulation

The term triangulation refers to the different use of different sources (Data triangulation), the use of different researchers (Investigator triangulation), the use of different perspectives to interpret data (Theory triangulation), or the use of different methods to one research inquiry (Methodological triangulation) (Denzin and Lincoln

2000). Those are patterns where the researcher is trying to develop or support an overall interpretation of the phenomenon under scrutiny (Denzin and Lincoln 2000). This position is supported by Hammersley and Atkinson (1995), where they view triangulation as a form of 'navigation' where two landmarks give better directions than one. They argue that the use of different techniques of triangulation might provide an additional depth to the 'description of the social meanings involved in a setting' (Hammersley and Atkinson 1995). In addition, one might argue as well that the use of multiple methods might result in less bias as opposed to a single method and therefore strengthens the data.

Hammersley (1990) states that there are very rare explicit examples of triangulation in ethnographic research, a concept originating from Lever (1981 cited in: Hammersley and Atkinson 1995). The same example is used by Hammersley and Atkinson (1995). Lever (1981) in her research on sex differences in children's play, compared questionnaires and diary data. She hoped that the use of different sources would confirm one another, as it is believed by many researchers (Lever 1981 cited in: Hammersley and Atkinson 1995). However, as Lever (1981 cited in: Hammersley and Atkinson 1995) concluded, there were major discrepancies amongst the results of the two methods used that could lead to different interpretations (Hammersley 1990). As Silverman (2000) argues that everything should be understood in its own setting and that every aspect surrounding it should be taken into account. Therefore, triangulation could be used as a tool to provide data from different settings in order to gain more understanding of the phenomenon under study and not only to compare settings or demonstrate differences amongst the data collected (Silverman 2000).

Although there is an agreement on the use of triangulation as a means of strengthening the data, the question exists as to what extent triangulation could be viewed as a technique of testing validity of the findings (Silverman 2000, Morse 1991, Angen 2000, Hammersley and Atkinson 1995, Fielding and Fielding 1986).

5.8.3 Member check

Member checking or respondent validation, involves returning to participants, consulting them and asking them to read on the data and comment on the findings and the interpretations of the investigator (Lincoln and Guba 1985). The purpose is for the informants to recognize that all the above represent their own realities and to be able to comment on them (Lincoln and Guba 1985). In addition, Hammersley and Atkinson (1995), indicate that informants might as well have access to additional information regarding the context that may not be available to the researcher. That could also give the inquirer the opportunity to refine the findings based upon respondents' reactions and additional information (Silverman 2000). Members check is also recommended by Miles and Huberman (1994) and Brewer and Hunter (1989). It all supports Van Maanen's (1983) comment that analysis and verification is something that you bring along from the field and not something you attend to later.

However, there are limitations on the respondents' validation and in some cases criticism on whether it should be used or not (Sandelowski 1993, Morse 1994). Sandelowski (1993) argues that that the informant – inquirer relationship, might

influence informants' decision to participate in the validation process or their readiness to disagree with the researcher's interpretations. It is also suggested that most participants are often more interested in descriptions of their own accounts that represent multiple realities. This makes it difficult for the informants to comment on an account that incorporates many views which might be different from their own (Sandelowski 1993, Mays and Pope 2000). Besides this, the informants might not recall their account exactly and deny things that they have said before for various personal reasons (Hammersley and Atkinson 1995). Therefore, the researcher should be aware of all these limitations when employing such techniques.

There are both *informal* and *formal* ways of member checking, such as to 'play back' an interview and see the respondent's reaction (Lincoln and Guba 1985). The researcher of this inquiry asked the informants to read any transcripts of dialogues in which they have participated. Since a tape recorder was used for the interviews, the emphasis was on whether the transcripts matched the participants' words and captured exactly what they wanted to say. It was very difficult for the researcher to go back when the categories were formulated since she was in another country to that of the research. She recognizes that this might be a possible limitation but distance was a major obstacle and she explained all that to the participants. However, to eliminate this limitation as much as possible, the researcher employed the 'peer debriefing' technique.

5.8.4 Peer debriefing

A researcher would invite a colleague to read the transcripts and explore the data to confirm accuracy of the interpretations. Peer debriefing exposes the researcher to the searching questions of others who are either experienced researchers or experts in the phenomenon under scrutiny (Lincoln and Guba 1985). It is a useful process that allows the researcher to become fully aware their position and process, to test any working hypothesis and to provide an opportunity to evolve any methodological issues (Denzin and Lincoln 2000). However, critics argue that it is very difficult for someone that has not been part of the inquiry to judge if the interpretations made were right or wrong (Morse 1994). Sandelowski (1993) extends her argument about peer debriefing into more philosophical pathways regarding the nature of naturalistic paradigm and expresses her antithesis. Nonetheless, peers could always check whether the inquirer has argued correctly and written persuasively (Angen 2000).

Burnard (1991) suggested inviting a colleague, who is not involved in the study, to independently analyse some of the transcripts and develop a category system as a means of checking the validity of the findings. Given the nature of the particular study, conducted all in Greek, it was not easy to find individuals who could deal with the data itself. Furthermore, the researcher agrees with Munhall and Boyd (1993) that it is not feasible for two individuals to form the same categories and interpret the data in the same way. This is because data analysis is a unique process between the researcher and the data (Munhall and Boyd 1993). However, the researcher following Burnard's (1991) suggestion, and invited two Greek speaking experienced academic researchers who read the transcripts and then commented on the categories and

subcategories developed. It was a very interesting experience regarding methodological arguments and various interpretations.

The researcher also had regular consultations with both supervisors who are indeed experts in the field of qualitative research and ethnography in particular. Although Lincoln and Guba (1985) suggest that the debriefer should not be someone in a position of authority to the researcher, in this case their role was primarily advisory and evocative. In addition, they checked the categories and subcategories that emerged and made suggestions. Hence, all the discussions with the supervisors regarding methodological issues and the process of analysis were invaluable and guided the researcher to audit trail her decisions. Moreover, there were opportunities for feedback from peers during presentations (e.g. seminars) given in the duration of the project. Those comments were very useful as they were bringing new insights to the researcher's account. Thus, all these questions and observations enabled the inquirer to develop a greater explanation of the research design and strengthen her arguments in the light of the comments made.

5.8.5 Transferability

Lincoln and Guba (1985) use transferability instead of external validity (or applicability) and they suggest that it is concerned with the extent to which the findings of one study could be applied to other contexts. In the positivist paradigm it is always of primary concern that the results are applicable to a wider population, whereas the findings of a qualitative account involve small sample sizes and specific

settings (Lincoln and Guba 1985, Shenton 2004). Thus, many naturalists believe that generalisability is not achieved within the qualitative inquiry, because all the observations are defined by the specific contexts they occur (Erlandson et al 1993).

Lincoln and Guba (1985, p:316) propose a technique named ‘thick description’, which could ‘enable someone interested in making a transfer to reach a conclusion about whether transfer can be contemplated as a possibility’. They do not propose however, a specific definition of ‘thick description’ as they claim that it is not a completely resolved issue (Lincoln and Guba 1985). The inquirer is held responsible though, to provide as much information as possible to the reader about the fieldwork, the setting and all the steps taken to achieve the data (Lincoln and Guba 1985). It is very important then, that sufficient thick description of the phenomenon under investigation is provided to allow readers to have a proper understanding of it, thereby enabling them to compare the instances of the phenomenon described in the research report with those that they have seen emerge in their situations.

In this project the researcher gives detailed accounts about the organisation involved and where it was based. Detailed accounts of the sampling method and the sample size with the inclusion and exclusion criteria are also provided. The use of purposive sampling in this project is also highly recommended by Lincoln and Guba (1985) on their discussion about thick description. There is a very detailed description of the setting as this was part of the observation component. The setting of the interviews,

the informants and the techniques used are also described in detail. Finally, the time period of the data collection is reported.

It is worth mentioning that the sample size used for this project was small in contrast to quantitative projects and there was only one organisation involved. This might be considered as a limitation of the study compared to bigger projects. The researcher has always had in mind that the aim of naturalistic inquiry is not generalisability, but a detailed account of the phenomenon under study in a particular environment. However, the researcher tried to elicit information from various groups within the organization to broaden the representation within the organization and the phenomenon under scrutiny. Nevertheless, a qualitative study should be understood within the context of the particular environment it takes place and perhaps within the specific geographic characteristics it occurs.

5.8.6 Dependability

Dependability refers to what the conventional paradigm so-calls reliability or as Lincoln and Guba (1985) refer to it as consistency. Silverman (2000), Lincoln and Guba (1985) and Denzin and Lincoln (1998) agree with the definition Hammersley (1992) suggests that reliability is about the consistency that the data shows in the individual category when studied by the same or different researchers.

The issue of reliability is debatable within the context of qualitative research. When used within the conventional paradigm it refers to the exact duplication of the study

within the exact context (Silverman 2000). This appears to be rather easy, because there is a set framework given and everything is calculated (Tindall et al 2001). However, there is no such case in a qualitative study that involves human beings and is set within a social context (Tindall et al 2001). It is almost impossible by replicating in the same setting with the same people to produce exactly the same results as the initial study (Denzin and Lincoln 1998). This is because humans will never reproduce the same words or the social context will never be exactly the same again (Lincoln and Guba 1985).

What is suggested for the qualitative research is to have a consistency rather than exact replication (Lincoln and Guba 1985). That means to have approximate results when research is repeated under similar conditions (Tindall et al 2001). In addition the researcher has to always '*take into account both factors of instability and factors of phenomenal or design induced change*' (Lincoln and Guba 1985, p:299). For instance, in the current study, the researcher collected data via semi-structured interviews and observations. An interview was a dynamic interaction between the researcher and the participants. The participants described their reality at that time, in that place and under specific circumstances. The researcher believes that if she had interviewed the same participant at another time, under different circumstances, the interaction would not have been the same, but there would be some stability in the participant's descriptions because they arose from their personal beliefs and experiences.

Many authors have suggested ‘auditing of the decision trail’ by the researcher as a means of enhancing dependability in qualitative research (Lincoln and Guba 1985, Denzin and Lincoln 1998, Sandelowski 1986). However, it is suggested from Lincoln and Guba (1985) that if the audit trail is managed properly, it could establish dependability and confirmability at the same time. The concept of confirmability and audit trail is going to be explained furthermore subsequently.

5.8.7 Confirmability

Confirmability refers to the ‘objectivity or neutrality of the data’ (Polit and Hungler 1999). According to this definition the focus is shifted from the researcher itself to the data. The researcher is no longer the primary issue but the data themselves. It raises the question of how confirmable the data are. The particular definition is preferred by Lincoln and Guba (1985) and most naturalists because it speaks more of confirmability rather than objectivity. Sandelowski (1986) agrees to the notion that objectivity in the qualitative inquiry refers to the researcher’s detachment and standing back. This means that data collection and analysis are usually conducted in such a way as to be free from bias on the part of the researcher.

To assess the confirmability of the findings, two questions need to be asked. First, are the findings, conclusions and recommendations supported by the data? Second, is there internal agreement between the researcher’s interpretations and the actual evidence? (Talbot, 1995). Researchers must clearly present how a conclusion has been reached to enable readers to decide about the confirmability of findings. Nevertheless, the nature of qualitative research should always be acknowledged and

remember that the interaction between the researcher and the informants are very personal and cannot be replicated.

5.8.8 Audit trail

An audit trail involves “the researcher providing a clear decision trail considering the study from its beginning to its end” (Sandelowski, 1986, p.34). The main aim of an audit trail is to allow readers to follow the pathway of decisions made throughout the study and to understand its logic so that they can decide on the worth of the study (Long and Johnson, 2000). An audit trail is useful for both the researcher and readers of the report. It allows the researcher to process the research and the reader to understand the decisions taken (Holloway and Wheeler, 1996). Denzin and Lincoln (1998, p:77) report the six types of documentation that according to Halpen (1983 cited in: Denzin and Lincoln 1998) should consist the audit trail: raw data, data reduction and data products, data reconstruction and synthesis products, process notes, materials relating to intentions and dispositions, and instrument development information. This shows how detailed the audit trail should be and therefore, it does not leave gaps for questions and clears many assumptions.

In the current study, every effort was made to provide a complete description of each stage and an explanation of the decisions taken throughout each phase. As suggested by Sandelowski (1986), the researcher has explained how she became interested in this project, the main aims of the study, the rationale for the choice of the research method, the process of data collection, the translation related decisions, the process

of data analysis, and the categories and subcategories developed to contain the emerged dimensions of quality.

5.9 Data Analysis

The meaning of ethnography lies within peoples' views, perceptions and actions in a particular environment or situation (Hammersley and Atkinson 1995). Interviews and detailed observations used to gather the data available. However, the question might arise is "what I am going to do with it". It is therefore very important to utilize all this data and have the results required. The only way to achieve this is by analysing the collected data. Data analysis in qualitative research refers to the process of making sense of data (Morse and Field 1996, Silverman 2000). It includes breaking down the data and searching for categories, which are then linked to form themes (Holloway and Wheeler 1996). The purpose of data analysis is enabling us to manipulate a large amount of data so it can be synthesised, interpreted and communicated (Morse and Field 1996).

The purpose of data analysis in an ethnographic study should explicitly interpret the meanings and functions of human actions (Reeves et al 2008). Findings of an ethnographic study should be in line with its aim to provide 'insights' of people's culture and perspectives (Hammersley and Atkinson 1995). Therefore, it is up to the researcher to identify the appropriate analytical approach in order to give meaning to his/her data. In this particular study Burnard's thirteen steps of analysis was used (Burnard 1991).

The aim of this particular analytical process is to ‘produce a detailed and systematic recording of the themes and issues addressed in the interviews and to link the themes and interviews together under a reasonably exhaustive category system’ (Burnard 1991, p:461-462). Burnard (1991) gives an explicate guide of every single step taken in order to reach the final result. It is made clear that there are no simple rules to formulate categories and that it requires a lot of effort and critical thinking (Burnard 1991). It might be argued, however, that the process could be more subjective, rather than objective. Therefore, Burnard (1991) suggests the involvement of other researchers in the formulation of categories and subcategories. Apart from that, various other ways such as members check and audit trial were discussed earlier as means of enhancing validity and reliability to the data presented.

The method of analysis used for this particular research were Burnards’ (1991) the thirteen steps of analysis. The primary reason was that the founder of this particular method was the researcher’s supervisor for this project. Therefore, the researcher was able to have individual supervision tutorials from Professor Burnard himself. The researcher was able to have the method demonstrated by the founder itself and have continuous help in every stage of data analysis. In addition, all data gathered was in Greek language and it would not have been possible to use computerised analysis which meant to be for Latin based character languages. It is worth mentioning that by using this method, the researcher was able to part of every step of the analysis and identify every factor that played role either during data collection or during the analysis process. Hence, a pilot study was undertaken in order to ensure the researcher that she could incorporate as many of the elements above as possible.

5.10 Pilot Study

A pilot study was conducted around six months prior to the main study. The main aim was to ensure that ethnography was the appropriate methodology to generate the information wanted. Also it was the only way to check the methods used i.e. interviews and observations. In addition it was very important for the researcher to check the clarity of the language of the questions. The researcher prior to the pilot study did some mock interviews with co-researchers to familiarise herself with the interview technique. The researcher's supervisor also contributed to her development with the interview technique by doing mock interviews and addressing issues around it. The researcher also aimed that the pilot study would help her to confirm the observational foci and familiarise herself with the particular environment. Finally, it was a good way of assessing how the informants would experience the whole process and how they would react to it. Hence, all these would enable the researcher to assess the practicality of the study and make the amendments necessary prior to the main study.

The system regarding access to the hospital and conducting research was partially different than the United Kingdom. Access for my pilot study was verbally granted by the hospital's matron and the midwifery director. One of the senior obstetricians was asked and granted permission. However, I was permitted to contact interviews only and that is with doctors and midwives themselves. I was not permitted to do any observations or contact any women at present. In order to conduct the main study to

its full extent, I should have had written consent from the Hospital's Scientific Committee. Details on gaining access are going to be explained in the following chapter.

Three midwives and two obstetricians were interviewed for the purpose of the pilot study. All five of them were very supportive and friendly with the researcher and tried to be as informative as possible. After the data collected the interviews were transcribed. One of them was discussed with my supervisors and the rest with a bilingual experienced researcher. The pilot study itself was an opportunity to develop my methodology and to refine the procedure to utilize in the main study.

5.10.1 Data analysis and findings from the pilot study

Burnard's (1991) thirteen steps of analysis were used to analyse the data obtained. The researcher tried to focus on each suggested step. Categories and subcategories were formulated after extensive work and going through the transcript several times. Both the researcher's supervisors and the bilingual researcher expressed their opinion on the formulation of categories and subcategories. Obviously, the reason of the pilot study was not to produce extensive findings because the sample was very small. However, a few themes emerged as well as some methodological issues during the pilot study.

Both obstetricians and midwives expressed their concerns about the heavy workload and the time constraints in order to care for women in plenty of time and allow them

to express themselves. They both also referred to how difficult were for the women to open up due to the fear of being labelled or stigmatized. Despite the fact that both groups' opinions merged on the above areas, midwives were very sceptical about their role and how much they were allowed to do. However, as the scope of the pilot study is different, the researcher amended a few questions where the meaning was not clear for the respondents to understand. Moreover, during the pilot study, the researcher came across a few methodological and cultural issues and tried to address them.

5.11 Methodological and cultural issues

The first thing the researcher came across was the fact that almost anyone was aware of qualitative research and the use of interviews as means of collecting data. People were more aware of questionnaires as the only data collection tools apart from experiments. However, there was not enough exposure of qualitative methods to the medical world until recently (Savage 2000). The researcher tried to explain the use of qualitative research and what it involves facing continuous suspicion. The researcher realized that she needed more time to go through this initial phase and the time dedicated for the pilot study was inadequate. Nevertheless, she decided to invest more time on this approach during the main study phase.

The unfamiliarity with the interview component, made the participants being reserved with the interviews at the beginning especially with tape recorder. Midwives were more hesitant than the doctors to accept the use of tape-recorder. The researcher explained the purpose of it and their right not to be recorded (Kvale 1996). After that none of the pilot study informants refused the use of tape-recorder.

Another issue that emerged was the fact that the concept of postnatal depression was commonly mistaken with maternity blues. The researcher initially tried to explain to the informants that this was a completely different subject, but subsequently it was regarded as part of the information obstetricians and midwives had on postnatal depression. Overall, the researcher felt that most of the goals set for the pilot study were achieved and that she had to address the issues that arose and prepare for the main study.

5.12 Summary

This chapter has discussed the methodological issues underlying the current study, including the reasoning for the choice of a qualitative approach and the use of ethnography to elicit obstetricians', midwives' and women's perceptions regarding the quality of maternity care towards postnatal depression. The pilot study has also been described and the issues raised have been highlighted. The next chapter continues the presentation of the research process and describes the data collection process and presents the process of data analysis.

6. DATA COLLECTION AND ANALYSIS

6.1 Introduction

The current chapter is going to present the journey of the data collection process and analysis until the final findings of the study obtained. The process of gaining access, the ethical considerations, the setting and the participants and the factors affected the research procedure are presented in the chapter. In addition, the issues arose regarding the translation from Greek to English are discussed. Finally the process of formulating the categories and the themes as well as personal reflections is illustrated.

6.2 The data collection journey

6.2.1 Gaining access

Gaining access according to Holloway and Wheeler (1996) primarily involves the contact with the target people and the access to important documents. The researcher had to obtain ethical approval from the Hospital where the study was to be conducted. The necessary paper work was filled with an application and was submitted to the committee. It worth's mentioning that when the researcher submitted her papers to the committee they immediately asked where the questionnaire was. The researcher had to refer to her proposal and tried to convince the committee about the aims of qualitative research for her project to be considered for ethical approval.

Three months later a positive decision was made and the researcher had the approval to conduct the study if the clinical director of the obstetrics and gynaecology department agreed. The researcher had to arrange to be interviewed from the particular consultant and explain the research process and the benefits for the hospital. After the interview, access to all maternity departments and permission to conduct interviews and observation was granted. Following the interview the researcher had to approach the rest of the 'gatekeepers' (Holloway and Wheeler 1996). The researcher before entering any department wanted to inform the sisters in charge of every department and ask for their permission if they were happy for her to proceed. All the sisters from the delivery suite, the antenatal clinic and the postnatal and antenatal ward were more than happy for me to be present and obtain all the information required. The researcher was very keen to start her research projects in one of the biggest University Hospitals in the North West region of Greece. However, for confidentiality purposes the name of the hospital will not be revealed.

6.2.2 Access to midwives and doctors

The first group of participants I gained access to was the midwives. There were all welcoming and they wanted to make me feel comfortable. They were very proud that a fellow midwife was attempting to obtain a higher degree and they all seemed very keen to help. When the researcher gathered them to talk to them about the project they all started asking where the questionnaire was and they could not understand what kind of research was the one that I was doing. After an extensive dialogue the midwives were convinced that I knew what I was doing and they were pleased to help. The researcher explained all the issues of anonymity and confidentiality. In

addition the researcher emphasised that her aim was to explore the care given from their perspective and not to judge any of the practices.

Gaining access to the doctors was more difficult as it was impossible to gather them and speak about the project. Therefore the researcher had to conduct each doctor in person and explain the research procedure. The reason they could not gather was their timetable and the different tasks they had to perform in different departments throughout the day. It might have been time consuming but in the end the researcher managed to recruit ten obstetricians.

Although the access stage took longer than anticipated, the researcher thought of it as a fundamental step in the research process. The experience of conducting different people from different places was very informative in regards with the local policies and the context of care. It also allowed the participants to understand the researcher's role and prepare them to accept her presence in the setting.

6.3 Participants

Seventeen midwives and ten obstetricians were selected to participate in the study. The inclusion and exclusion criteria for the study were thoroughly explained in the Methodology chapter. Sixteen midwives were female and one male. Nine obstetricians were male and one was female. The researcher knows that she should be politically correct but for anonymity and confidentiality reasons the midwives

referred as she and the obstetricians as he. A summary of the participants' characteristics is presented in the following table.

Demographic data		
	Midwives	Obstetricians
Age of participants		
20 - 30	3	0
30 – 40	10	5
40 – 50	3	3
50 – 60	1	2
Gender		
Male	1	9
Female	16	1
Years of experience		
1 -5 years	3	2
5-10 years	10	4
10 – 20 years	4	4

Table 3: Demographic characteristics of the study participants

6.4 The stages of the interview

The interviews were conducted with the midwives in the coffee room and with the doctors either in the doctors' room or in their offices. Some of the senior obstetricians had their own office. An interesting point was when the researcher asked them to read and sign the informed consent and participation in the study. The participants were impressed with the researcher's organisation but they thought of it as unnecessary. They argued that they trusted the researcher and a verbal consent would be enough. The researcher had to explain in every participant the use of this procedure and after that they were all happy to sign. They were all very friendly even if some of them were nervous initially.

6.4.1 The interviewing process comprised three stages:

First stage

Before each interview the researcher reminded the participants about the purpose of the study and emphasised the fact of anonymity and confidentiality. The opportunity to withdraw from the study at any stage was made clear to all participants. The informed consent was read and written consent of participation was signed. The interview was conducted with only the researcher and the participant alone. The researcher was trying to relax the participants by speaking for approximately ten minutes about general matters such as the family or the weather. Finally, the respondents informed that they could stop the interview at any time especially if did not feel well.

Second stage

An interview guide adopted as mentioned in the Methodology chapter. The scope of was to guide the researcher and keep the participants focused in the topic under study. The researcher started by asking about their work experience and what led them to follow their profession. Then the discussion was proceeding with the researcher asking them what was the information they had regarding postnatal depression. Then the researcher was asking them about their personal experiences regarding postnatal depression. The discussion was moving along depending on their answer. The researcher was trying to elicit more information concerning the diagnosis and the management. The focus then was shifting to the perception of their role and what was their attitude towards postnatal depression. The particular environment and its influence were then discussed followed about the effects of the family. The last theme arose during the researchers observations and the extensive involvement of the family observed. Their suggestions on the improvement of the maternity care towards postnatal depression followed. Finally they were asked if there was something else to mention regarding the study.

Third stage

The interviews lasted from thirty to sixty minutes. After the end of the interview the respondents were asked if everything was all right and if there was something they would like to discuss. No respondent has dropped during the interviews. During the interviews the midwives were less confident to share their experience than the obstetricians regarding mental health issues. On the contrary midwives were more expressive regarding their role and the influence of the family. Obstetricians were shorter in their responses but many times substantial. No particular problem arose

with the use of the tape recorder especially after the full explanation of its use during the first stage.

6.5 Transcribing the interviews

Following every interview the tape was dated and labelled with a code number on the same day of the interview the researcher was going to her house in a quiet room and she was replaying the tape to develop familiarity with the data. The interviews were then transcribed as soon as possible following the interview. Pauses, interruptions, signs of hesitation or anything else occurred during the interview was transcribed. The researcher's thoughts and reflexions were noted after each interview. The interviews were all transcribed by the researcher because she wanted to become as familiar with the data as possible. A copy of the transcript was available for any participant who wanted to have one. It is surprising that none of the participants asked for a copy.

6.6 Observations

As it was mentioned in the previous chapter the use of observations was an inseparable part of the study. The researcher had arranged with the gatekeepers to observe any area of the maternity services she felt she had to. Observations were conducted in the antenatal clinic, the delivery suite and the postnatal ward. The observations were held for a period of four weeks in the antenatal clinic, two weeks on the delivery suite and seven weeks on the postnatal ward.

After extensive thinking the researcher left delivery suite after two weeks as she felt a) uncomfortable and b) there was not enough data to be obtained. Women were in their rooms and the researcher had no right from the ethical point of view to be present and observe any kind of care. In addition this was going beyond the scope of the study. The researcher drew the layout and had conversations with the staff during their interviews.

On the antenatal clinic the researcher observed the layout of the clinic, the amount of people in the waiting room and the time spent in each consultation. In addition the researcher had access to the clinic's protocols and the list of standard questions asked regarding history taking. She was discussing with the staff and observed their routine during the course of the day.

On the postnatal ward similar aspects were observed. The layout was drawn; the routine of the staff was observed and had access to the protocols of the clinic. The researcher observed the handover between shifts and she could be present in the staff room where she could talk with the staff and asked them to reflect on their day.

No episodes of care with women in their rooms were observed either on the antenatal clinic or the postnatal ward, as this was beyond the scope of the study. The researcher wanted to make it clear to the staff that she was not there to judge or interfere in any form of care. An interesting point was some women's reactions on

the present of the researcher's present. The researcher recalls a woman from the antenatal clinic.

'I am sorry can I ask you something'?

'Of course'.

'What are you doing here? I saw you the other day as well with your notebook sitting quietly in a corner of the waiting room'.

I explained my purpose of presence and the woman congratulated me for my effort. She asked me if the results would be made public and I reassured her that they would.

During my presence in the postnatal ward I could observe that the mother's of the women were constantly present on the ward and they did not wish to leave by any means. I witnessed episodes with staff trying to persuade them to go and their reluctance to comply with that. That is the reason the researcher thought to add a question regarding family.

Before entering any ward for observations the researcher informed the staff and explained why and how the observation was taking place. The researcher had a notebook with her at all times and she was immediately taking notes of every aspect relevant to the study. Initially the staff were not very comfortable with this and they asked to see what I was writing. The researcher complied with that and explained many times the purpose of it. After a week or so the staff became familiar with the

researcher's presence and they did not ask for anything else. After the researcher was leaving the hospital a reflection of the day was written in her diary. Initially all the observation field notes were transcribed as being an interview transcript. Afterwards they were thematised and categorised, in a manner that raw data will be transform into units that will allow the description of similar and relevant characteristics (Lincoln and Guba 1985).

6.7 Presentation of the findings in another language

All the data gathered was in Greek, which is the native language of the country. However, the research should present it in English and that has required a number of decisions. What was going to be translated, who would do it and how she could enhance the validity of the translation were the main issues the researcher had to think about.

The researcher discussed the issues with her supervisors and some research colleagues and the decision was made to analyse the data in Greek and present the findings it in English. The researcher felt that this was the most appropriate approach as the data would make more sense analysed in its own context. The researcher translated a couple of interviews and a private consultation with her supervisor and founder of the thirteen steps of analysis Professor Philip Burnard (1991). The purpose was to ensure that the method was accurately followed. The researcher translated the issues emerged from the data because she wanted her supervisors to be able to comment on the formulation of the categories and themes.

It is very important that the accuracy of the translation and any loss of the meaning could affect the validity of the study (Birbili 2000, Rubel et al 2003). The researcher decided to do the translation herself as she was familiar with the data and all the medical terminology might have been used. However, to ensure the validity of the translation, two bilingual academic researchers confirmed it.

6.8 Data analysis

The main aim of the data analysis was to formulate categories and themes that arose from the study and depict the issue explored. Both the interviews and observations were transcribed as text and used for the analysis of the data. In addition reflective thoughts from the researcher's diary were used to enhance the process of the analysis. As it was mentioned earlier on Burnard's (1991) thirteen steps of analysis were used to analyse the data and rich to the formulation of the final categories and themes.

The first step taken was to read the transcript fairly quickly and mark the different issues with a different coloured pen. Then all the quotes with the same colour were gathered. The same coloured quotes were representing similar meanings. Those were read again and different colouring was used to gather the ones with the closest meaning. This process continued until all the quotes with the similar meaning gathered together. The overall concept arose formulated the categories of the data and the quotes of similar meanings formulated the themes under the categories.

An example is given from the final stages of the analysis process as the analysis was done in Greek.

Category: dissemination of information

Theme 1: Sources of information

Conferences

Assignments

University lectures

Papadopoulou

I couldn't say that there is enough information regarding this topic. Only what I know from the midwifery course. Anyway, is something that we don't come across very often. Or we don't see it. I don't know.

Personal interest

Articles

Mpekiropoulou

No, there is not enough information. And me personally I've heard about it in some conferences or from some colleagues' papers or some journals. Nothing much but a few things here and there and not something concrete. You know substantial. Not at least where I am working. Maybe I didn't care about it too much. Not really interested.

Mass media

Internet

Work experience

Theme 2: Reasons for lack of information

Disregard

Heavy workload

Stressful job

Hard schedule

Initiative

Financial capability

Lack of study days

These were the concepts arose from the data that helped to formulate the categories and themes. After that they were all presented in two tables, one for the obstetricians and one for the midwives and represent the final categorise the themes emerged through the data analysis process. The researcher went back to the field and asked the respondents to check the categories and themes. What took the researcher by surprise was the respondent attitude to that request. They all answered that they did not want to be involved and that they were sure that the researcher herself was doing a good job; despite the fact that the researcher tried to explain the reason for doing that. It could be assumed that the respondents were not feeling confident with the whole procedure and they were afraid that they might be criticised.

As it explained before vast majority of the analytical process was done in Greek language. Therefore, the researcher wanted to ensure the validity of the final categories and themes. Thus two academic bilingual researchers familiar with

qualitative research were invited to put the meanings emerged under categories and see if there is a mutual agreement with the researcher. There were only few discrepancies following the procedure. However, after extensive discussions with them alone and the supervisors the researcher adopted her findings as she was present during the data collection and knew the concept of the data better than anyone else.

6.9 Summary

This chapter presented the journey of this study throughout the time and the various stages of the research process. The process of gaining access and getting into the field was described. The interviews and observations used as data collection methods were also discussed. The collection of data in one language and the presentation of the findings in another one were mentioned. Finally, the process of the data analysis was described as all the measurements taken to enhance the validity of the study.

7 PRESENTATION AND ANALYSIS OF THE MAIN FINDINGS AROSE FROM THE DATA

Chapter four primarily presents the main findings from the data collected for this particular study. An analysis and discussion of the findings follows the presentation. As described in the methodology chapter, the analysis consists of the identification of themes and categories that emerged from the interview and observation data.

After thorough study of the data obtained, a set of dominant themes and categories emerged. These are presented in the tables 4.1 and 4.2. There are two separate tables, one referring to the midwives interviews and observations and the other referring to the obstetricians.

The identification of the dominant themes and categories required extensive analysis of the data collected. During this analysis it became evident that some aspects of the data fitted in more than one category. To overcome this difficulty it was decided that the categories need to be organised so that they are representative of the entire range of the data. This was achieved by collapsing some of the themes and merging them into one. Through this process the themes and categories that emerged from the data were finalised. Advantages and disadvantages of the choices made are discussed within the framework of each topic. The tables of the themes and categories that emerged are as follows:

7.1 DATA OBTAINED FROM THE MIDWIVES INTERVIEWS

Categories	Themes
1. Workload management	1.1: Working conditions 1.2: Time management 1.3: Human resources limitations
2. Hospital environment	2.1: Diverged views over the hospital environment and its influence on women Delivery Suite Ward environment 2.3: Unlimited visiting times
3. Dissemination of information	3.1: Sources of information 3.2: Reasons for lack of information 3.3: Professional development
4. The role of midwives as care providers	4.1: Self-perception of the midwives role 4.2: Communication skills 4.3: Interpersonal relationships
5. Midwives perception on causes of mental health problems	5.1: Personal account of midwives experiences 5.2: Main focus on physical care 5.3: Follow up in every stage of pregnancy by obstetricians 5.4: Postnatal care

6. Midwives perceptions on effects of postnatal depression	6.1: Stigma 6.2: The role of the family
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Table 4: Data obtained from the midwives interviews

7.1.1 Workload management

The first category identified was labelled ‘workload management’. This contains data regarding the working conditions, the lack of time and lack of adequate resources. Although lack of time and resources are interrelated they will be treated as different because there are many accounts referring to them on different terms. Importantly, every single respondent refer to some of the themes within this category. Moreover, their views where similar, and the lack of staff and time were of primary importance.

7.1.1.1 Working conditions

The first theme that arose had to do with the working environment and what the respondents feel about it. It is worth mentioning that some of the respondents expressed strong views over working relationships and how general work mentality affects their performance.

Xenia

They don't accept changes, you know... We don't accept changes because we know everything. And I don't say that I know everything. Because, to be honest, I am not as experienced as many others here. And yet, even some senior members of staff 'don't

know much' [wishes that to be in inverted commas]. There are many times that I see colleagues more experience than me making mistakes and that's because their mind is stuck in old theories. They don't move forward. They are not willing to say: 'I will read about it'. 'Where did you read about it?' 'Where did you learn about it?' They don't accept that. What they say is the law in this place. They don't accept changes. With capital letters the phrase 'they don't accept changes'... Whenever you say something they thing... [pause] just leave it.

The respondent here is trying to express her disappointment over a certain mentality that overrules according to her the current system. She is using the phrase 'don't accept changes' a few times in a rather strong manner. There is a belief that this mentality is holding back the provision of services and hinders development. The following respondent is expressing her opinion in a similar manner.

Natalia

Of course we have the civil servant mentality. That's exactly what we have. Just do my job and go. Not to even get up from your chair if that were possible. Because that's how we know it and no one feels like changing it. Do you know what everyone feels? Why only me? Let the others do it.

On the account above there is a comment on civil servant mentality, connected with no motive for the job and job satisfaction. The respondent also holds this mentality accountable for the fact that there are no changes forward. The following respondent is talking in an analogous tone.

Panagiota

What I am saying is that there is nothing of interest for us more in this place, rather than to come, do our shift and go. We don't care about the women. Women are in pain. They don't lie. Yes, they are in pain.

Once again there is a repetition of the phrase 'do our shift and go'. She gives the feeling that there is no further interest in the particular working environment. She however, extends her comment that this dissatisfaction makes them to not care about the women as much as they probably would otherwise. In a less outspoken way the next two accounts refer to a similar point of view.

Litsa

There is a general nonchalance. Oh, what I already know is enough. That's the mentality.

Xrisa

As far as the working environment is concerned there is dissatisfaction. There is moaning.

There is a feeling of dissatisfaction expressed in both cases. The respondent briefly talks about the mentality at work and how that prohibits seeking further knowledge. While respondent 10 points out a general dissatisfaction regarding the work environment. The following account is referring mostly to the working conditions and how they affect their performance as midwives.

Voula

We are talking about very hard working conditions...There is no spare time for anything. There is so much stress. You get more stressed during work by just trying to get everything done in a proper way... I do believe that due to major workload and stress during work we miss many things that have to do with a woman's psychological world. Because if I don't have the time to be with a woman as much as I should be and offer as much as she deserves to have, how could I understand what is happening inside her? It's all like a chain. They are interrelated. Even if you want to give something, it is very difficult to do so under these working conditions.

A very stressful working environment is how respondent 6 describes the current work conditions. She uses the word 'stress' to illustrate the reason of not paying enough attention to women. She clearly says that with the current working conditions women do not receive the psychological care they deserve. She portrays it like a chain where stressful working conditions and poor care are interrelated.

Observation

I am standing outside the antenatal clinic. It's seven o'clock in the morning and there are already twenty women to be seen. The midwife runs around trying to prepare everything. There is a woman complaining that her appointment was at seven and she has not been seen yet. The doctor has not arrived. The midwife apologises and trying to calm her down. The other women are patiently waiting.

There is an overall feeling that a certain mentality at work holds things back and does not give way to progress forward. Moreover, stressful working conditions result in the delivery of care below the standards expected. Evidently, revising the current work mentality seems to be a major component in an effort to bring more inspiration and give staff the initiative to deliver high standard care.

7.1.1.2 Time management

All midwives mentioned that lack of time is a downside to the care provided. They tried to make it clear that there is not enough time for them to do things properly. They said that despite the fact they are trying to do their best they wish they had more time to deliver the care that women deserve.

Efi

All the girls are willing to explain things to women regarding any topic. But that depends on the workload. Sometimes you might explain things twice or three times even if you are not obliged to do so. But you might not do it if there is a lot of time pressure and that depends on the staff available. You will do something that is not important for you but important for the woman only if you have the time to do so. When there is no time there is a limit to everything and the interpersonal relationships [with women] are not as they should be... Most of the time, when not enough staff is available, there is a general anxiety whether we will be able to do the things we should be doing. There is no time for us to sit down and discuss with women how they feel and if they have adapted to the new circumstances. Of course it depends on your character as well. But I do believe that we all insist on doing what has to be done first and then if you have time you will talk to a woman.

It is evident from the respondent above that lack of time is a major barrier for the midwives to provide adequate care rather than performing tasks. Midwives feel that they are oppressed by the heavy workload and staff shortages. There is a constant pressure just to perform the designated tasks and there is no time for further discussions. It is acknowledged that the main priority is the set routine of the department, otherwise the woman or the baby might be at risk regarding their physical well-being. This is probably the reason why there is a distinction over 'important' or 'not important' matters. This classification allocates women's mental well being to a subject of secondary importance.

Litsa

Unfortunately there is no time to look after the women properly. There is no time. Even if you see a woman upset or unhappy or crying etc... [pause] I dedicate maximum five minutes. Unfortunately, there is no more time to dedicate.

Although there is willingness from the midwives to dedicate time and cover with women all the aspects concerning both their physical and mental well being, this might not be feasible in the current setting. This might be an indication that the primary focus is presently for the mother to deliver safely and go home with her baby without any physical concerns. This mentality may result in inadequate response, such as commented by respondent 11 that even if there is a woman who is crying or being upset, not much attention will be paid. The reason is not because the midwife does not want to, but that she is bound from the system to accomplish all the tasks required within her shift. There are similar responses from midwives working across different departments e.g. antenatal clinic, labour ward, or postnatal ward.

Vaso

When we finish with the woman's history and all these formalities, I ask them if there is anything they want to say or whether something is bothering them. Of course only if I have time to do so. Especially on a morning shift there is no time for this kind of conversation. These kinds of conversations are better done in the afternoon. Unfortunately, we don't dedicate the time we should and that's because there is no time. There is not enough staff and you focus only on the necessary, the essential matters.

A similar response, from an antenatal clinic based midwife, shows that lack of time to approach women is a general phenomenon. It was noted, however, that it might be

possible to have a more substantial conversation with the woman during the afternoon rather than the morning. The difference as far as the antenatal clinic is concerned is that the afternoon clinics are private consultations and women who attend them may have more time dedicated to them. On the other hand, during the morning shift there is a general NHS clinic where everyone attends and most probably the time dedicated to individuals is very limited.

In spite of all the obstacles mentioned in the interviews, we consider very encouraging the fact that the midwives consistently use the word ‘unfortunately’ to describe the time allocated to a woman. This indicates an apparent willingness to invest time in an interpersonal relationship with women, even though this is generally not achievable.

7.1.1.3 Human resources limitation

Staff shortage is a comment made by all the midwives interviewed, and all midwives depicted this as a major drawback on the services provided towards women. They tried to highlight the need for adequate staffing levels which will allow them to provide the service they wish to provide.

Stella

Yes, a woman might open up to you if there is a good ground. Very easily. As long as she sees that there is a certain mood from the other side as well. Yet, this is very difficult. Especially when there are a lot of cases and very few members of staff. It is very difficult to sit down and offer proper care to a woman. Because there is not

enough staff. They believe that five to ten midwives can do the job. We can, but we could offer much more. Although there are no psychological resources to do so. We feel so tired from the workload that we don't feel like offering what we should be offering... The midwives do anything else but midwifery... [pause] Ok, they are midwives, but they do everything else as well which means they are acting as nurses. Personally I bath women and I get them up to go to the toilet. And I make the beds plus I have mopped the floor in the past. It is the same for all the girls. Just like the nurses do jobs that are not meant for them, such as housekeeping. I think it is appalling. I think that both nurses and midwives, and especially the nurses, are so capable.

The first comment made from the respondent above has to do with how easily the women could open up if the appropriate conditions were present. She also mentions that for this to happen a certain mood from the midwives has to exist which is very difficult to happen due to staff shortage. It might be that a pleasant mood or a sympathetic approach could help women to express themselves and reveal things that they would not do in other occasions. However, it is noted that a requirement for this would be that the midwives are stress free and in the right frame of mind. It might seem difficult to be pleasant and empathising when there is not enough staff and there is tremendous pressure to finish all the tasks required. Above all, however, such comments highlight the importance of how the staff's morale is affected and what the drawbacks from this might be. The downside of this is that women do not receive appropriate care and that they may return home with many problems, other than physical health, unresolved which may lead to great distress later on. Staffing issues might be a simplistic way to entirely justify the staff's behaviour and mentality, but it constitutes a recurring complaint.

Irene

Ok I don't think we are tired from the work itself only. But, if you have thirty women to look after and so many things need to be done, it is impossible that you will go and deal with each of them separately. If it was one midwife for three or four women then I believe things could have been much better. You could look after a woman properly. To ask her if she is coping well with breastfeeding or how to care for her baby. Many other things. Now you have thirty women and thirty babies. It is impossible.

Natasha

The point is that you haven't got the time needed with every woman in such cases. It is an issue of staff. If you are one and you have twenty women to look after, it is impossible to dedicate the time needed. I believe that many problems are due to the lack of staff. Because I do believe, with my limited experience, that these women would get a lot of help from some form of relationship and discussion. Just to explain things to the woman about her baby. If she is well informed about a few things before she reaches that stage maybe that will help.

There are comments from the staff on the number of women that midwives are able to look after for the care to be adequate. One midwife per four women seems reasonable and that allows the midwife to dedicate time to the women and cover all the aspects of care. Midwives think that breastfeeding or care of the baby is very important for the woman. This means that the woman will face less stress when she goes home if she feels comfortable with all the practical matters surrounding herself and the baby. She might have more time to herself and be more relaxed and face the everyday routine within a different spectrum. Midwives believe that discussion is of primary importance when they want to elicit information regarding a woman's psychological state. This might lead midwives to recognise primary symptoms of a vulnerable woman which she might need further attention in the future. In particular the issue that lack of staff forces midwives to perform duties other than theirs and

thus miss valuable time with women. These issues could be alleviated to some extent by support staff (e.g. auxiliary nurses) whose efforts need to be recognised and valued appropriately. It is apparent that highly skilled support staff could make a lot of difference in the department and help the midwives to perform their duties to maximum. There are reference to a further disadvantage that staff shortage might cause and its consequences.

Observation

It is the beginning of the afternoon shift on the postnatal ward and there is only one midwife coming for shift. I could see that her face changed when she realised it. I asked her how she was feeling and she replied that although she was not happy she was used to the situation. Then, she turned around and told me: 'see, what kind of care I am supposed to give'?

Vaso

We should dedicate more time to the women. But we need to have more staff for this to be done. We are really understaffed. There is not enough staff to cover the shifts on the ward, which results to arguments amongst the staff. Moaning. And when there is moaning there is neither quality of life nor quality of work. And who is going to pay the price? The people that are coming here to be looked after.

General dissatisfaction and an unpleasant situation are revealed. It is obvious that the staff is not happy with the current situation. It leads to low morale and prohibits the staff to operate in a satisfactory manner. It brings up how much this environment affects the midwives and their well being overall. This might have a serious affect to their own health and could result in sickness absence which will then leave the department with even less staff. Apart from that it could affect their personal as well

as their professional life. It is not desirable for their families to be affected by that situation and having to cope with all this extra stress. In addition staff relationships amongst themselves might be affected. This is rather risky considering the value of good relationships within the work environment. This will certainly influence the staff and their performance adversely. The most important thing is that ineffective cooperation and communication will impact upon the care given. As it is correctly mentioned by respondents, it is the women themselves who will 'pay the price'. This could result in women's care to be demoted in the sense that not every aspect of care will be properly and thoroughly covered. Nevertheless, different views on the matters exist.

Natalia

There are only a few women that are in a mood to talk and ready to open up. On the other hand is us as well not showing the best of mood. With the excuse that there is no time or that we are understaffed, we do only the necessary things and the rest are second or third class matters. I think it is our mistake. I don't know [pause]. On the other hand if you have five women you don't have five hands to give them. So we are coming back once again to the lack of staff.

Although the lack of staff is once again of primary importance there is suggestion of some other factors that might be responsible as well. The general mood of both the midwives and the women is acknowledged to be the missing link in communication between them. Many factors might be responsible for this. External factors seem more responsible for this rather than organisational ones such as no time or no staff. Maybe there are stressful life factors in the midwives lives such as childcare or intense family environment which leads to personal unhappiness and impact at work.

That might start a blaming culture where everything else, but us, is responsible for the whole work situation. Being generally stressed or unhappy might make the midwives to distance themselves from the women and provide only the care necessary. On the other hand women themselves may not wish to relate and open up to the midwives. Probably they feel that the reason they are in care is for them and their baby to go home in good health, plus acquiring the knowledge of a few practical matters. It might as well be that they see that the midwives are very busy or they are not interested in further conversations and do not attempt to form any kind of relationship. Or they might prefer to gain just some practical knowledge from the midwives, and discuss whatever else bothers them with their friends, partners or relatives. Whatever the case, the researcher wishes to end this theme with a short quote which, in her opinion, summarises the whole situation.

7.1.2 Hospital environment

Most respondents identified the hospital environment and the themes that emerged as a potential factor that might affect the care regarding postnatal depression. There is a speculation that the hospital environment might affect the individual's mental health depending of course on their personality. It is also mentioned that the environment plays a very important role on a woman's birth experience and how this might affect her. Themes that emerged were about the various aspects of maternity infrastructure such as the labour ward, the antenatal clinic and the postnatal ward. Another theme that emerged is the unlimited visiting time and its potential effect on the care women are receiving during their hospital stay.

7.1.2.1 Divergent views on the hospital environment and its influence on women

The current category reflects the midwives' perceptions over the environment and the layout of the maternity department. That includes the delivery suite, the antenatal clinic and the postnatal ward. The researcher divided them into two sub-themes according to the views that emerged from the existing data. Delivery suite is the first to be presented followed by the rest of the departments.

a) *Delivery suite*

The respondents here express their views over the delivery suite environment and how this could affect both staff and women. They talk about the layout of the particular department and its influence in their psychology. In addition the midwives comment on how the environment of the delivery suite could help or prevent women from feeling more relaxed and having a pleasant experience.

Tonia

I am under the impression that no woman would liked to deliver in that place. If a woman is claustrophobic, how can she deliver in such a place? I could not stand it as a midwife for eight hours to stay and work in this place. I think I could have suffered from institutionalisation. First of all you can't stand the colour. I don't like the fact that there are no windows. I don't like the fact that during delivery the delivery bed is facing the door and is not looking outside to the beautiful nature. So they can enjoy Giannena covered in snow. I think that's a very good way of self meditation. That's a way that women could use to relax themselves, instead of me speaking to them about relaxation techniques...Its' a impersonal place. There is a green colour that is presumably relaxing. I don't think that this particular green helps any woman to relax. I don't like it at all. And I also believe that if the women see other birthing environments none of them would agree to deliver here anymore. Or they will ask at least for the colour to be changed, or the general environment, or the lights. There could be a floor lamp for the woman to use if she wishes so. In addition I find

completely unacceptable the fact that a woman, which is fully dilated, gets up and walks to the delivery bed. I will never forget it as long as I live. No way.

The first quote that came up has to do with the aesthetics of the particular environment and how this might affect the woman's psychology and birth experience in general. There is a focus on the colours, the equipment and the way it is built and functions and a rather strong language is used to describe the place. The word 'claustrophobic' is used to give a succinct description of the delivery suite and the word 'institutionalisation' to describe the particular environment. This means that both women and personnel have to spend many hours within an environment that is not pleasant and might have serious drawbacks for their mental well being. The way it is laid out and the colours used might make both women and personnel feel very restricted and uninspired. The women's birth experience is possibly affected by not having the most appropriate environment to relax and feel comfortable. The lack of natural light and the particular colours might distress the women and make them feel that they want to 'escape' from the particular environment rather than this being part of a birth experience worth remembering. It is suggested that the layout should change and allow women to adopt a more relaxed atmosphere by having an outside view. This might help the women to feel more comfortable and have more focal points and distractions rather than the walls of a dark room. The same applies to the staff where they feel that having a better environment might have helped their mental well being and increase their performance. It is exactly the same words that are used from another respondent as seen below.

Panagiota

How the woman's psychological condition is affected after being in here for so many hours. If you think about it here it is like an ICU. And you know very well what they say about the intensive care syndrome. It drives you mad when you see four walls around you being painted in these stupid colours, a dark room with just air conditioning on top without a single window, without a nice colour. You are connected to the ECTG and all you do is listen to a monotonous noise from it. You have eight different people examining you vaginally, eight different hands. And you don't receive a vaginal examination from only a midwife and a doctor that you are familiar with. Oh, no. And what happens: he/she pulls the sheet down and says 'let me check a minute'. Pulls the sheet back down and most of the times does not explain the findings. If you are progressing, I mean. I think that this is a dramatic situation. I believe that the women are very tense at the time and they have a bad experience. They have a negative view of what has happened. That's why most of them when they leave they say they don't want another baby.

The ICU is mentioned which is synonymous to the institutionalisation and the side effects this environment has for the women. The words mental well being, performance and positive experience are interrelated according to this quote and there are not brought together due to the particular environment. It is mentioned that the woman's needs for a nice healthy relaxed atmosphere are clearly not met. The lack of natural light and the use of colours are mentioned as the primary factors that distress women and do not allow them to enjoy their birth experience to a maximum level. It might be that women are already distressed due to labour pain and it might have been useful if the environment was designed in a way that helps women to relax and focus more on their birth experience. This could prove helpful to help women to improve their perspective towards labour and encourage them in a future experience. Nevertheless, there is always the opposite opinion that judges the particular environment from a different perspective.

Observation

The corridor was a dark green colour the same as the delivery rooms. It is a beautiful day outside with lots of sun shine. It's a pity that there are no windows on the delivery rooms so the women can enjoy the light.

Xenia

The environment, the place is nice. The only drawback, and I emphasise this, is that [pause] that it is completely unacceptable for the woman to be transferred. It is completely unacceptable for her to get up and walk to the delivery bed (boum) like this. Otherwise, from an architectural point of view is perfect. Meaning the labour rooms are next to the delivery room. The resuscitate is exactly next to it as well. The theatre is there as well so it can be used in case of emergency. The anaesthetics department is just next door as well as the neonatal unit. You have no problem at all. The only thing, I insist, that is unacceptable is the fact that the woman has to walk to go to the delivery bed (boum). That is completely unacceptable. Apart from that everything else is around you. You are not afraid of anything. Is there is something wrong with the baby? You can take it and go straight to the neonatal unit.

The environment is characterised as nice but the emphasis is given to all the resources available. The perspective is different because the focus is on the woman and the baby's physical health. It is very important that all the units require immediate access like the neonatal unit are exactly next to delivery suite. This ensures that whatever happens to women or their babies it could be dealt with immediately. It is rather obvious that the physical health of both mother and baby is the main priority for the staff and it reassures them that all problems would be dealt in the best possible way.

On the other hand the drawback mentioned is the same as the one mentioned before regarding the women walking to the delivery bed. It is considered as unacceptable and it is a negative aspect of labour and it might traumatise women. When the

woman is fully dilated she has to get up and walk from the labour bed to the delivery bed where stirrups are applied. This bed is in the delivery room where all the equipment needed is available and minimises risks for the woman and the baby. However, no risk assessment is mentioned to ensure that no health implications arise from that. In addition, it might be upsetting for the woman and might affect her psychology in a future pregnancy or might stay as a bad memory in the current pregnancy. In a similar mode is the next respondent's answer.

Stella

I like the place. The only thing I don't like is the fact that the IVF unit has been transferred to us. And I don't like that for the women who receive the IVF treatment. Because there is many times that we have normal deliveries or caesarean sections and I come out with a crying baby in my hands to bath it and I am passing by a woman who had ten attempts to become pregnant and she cannot. I think this affects her psychologically and I don't like that at all. Or there is women pushing and there are women who are passing by to go for ovulation. Think how much they would love to be in the other lady's position. That is the only thing I don't like about the delivery suite. Otherwise, I believe is a very nice setting. I believe that it is a very convenient setting. We were not adequately equipped up to now, but thank God we are covered now. Ok, we could have had more technical equipment, but lets not be ungrateful, we are all right.

There is no critique regarding the environment apart from the IVF Unit. The only critique is that the IVF Unit is located within the delivery suite and it is probably inappropriate for the women under treatment. Apart from that she compliments the setting and the equipment. It is believed to be of convenience and adequately equipped. It is therefore a pleasant environment for the women and safe at the same time. The midwife shows the importance of the appropriate equipment and how essential it is for both the women and the staff.

From the quotes above it is rather obvious that there are conflicting perceptions regarding the environment. Some of the midwives think it is adequate and some not. For some of them it is highly significant that a nice and pleasant environment is very important for both the women and the staff. It gives the impression that it is vital to their psychological well-being which might affect either their birth experience or their work performance.

b) Ward and antenatal clinic environment

Apart from the delivery suite the postnatal ward and the antenatal clinic are the other two departments that are similarly significant for both the staff and the women. There is a percentage that believes that the environment is very nice and does not affect women. On the other hand the majority feels that the particular environment in both sites and the way they are running are not suitable for the women. However, what they focus more on is not the layout per se but the way the environment as a whole and the way it functions might affect women. An example is the following respondent's comment raising awareness on the influence women might have on each other.

Olga

Even the slightest of the things plays an important role. The way you are going to speak to her from the first time you will see her. Even the room you are going to put her plays an important role as well. It is also very important how comfortable you are going to make her feel. As a midwife you have to behave tactfully towards her especially when you know that there is a problem. There are many things that play an important role. It is also very important the fact that it is very noisy within the postnatal ward, there is too much traffic. Usually there are too many postnatal women. They meet each other and they exchange their experiences. That might be good of course. They influence one another in either positive or negative way. The

point though is that a woman might be influenced on a negative way by someone that has had a bad experience and make her think that 'oh this might happen to me as well'. The point is then not to lose the game in such a situation. When we see a woman which has negative thoughts influenced either by another woman in her room or by the ward surrounding in general. Because there are many relatives and visitors in the ward and everyone will express an opinion about something. At the end the postnatal woman will have a completely confused view of what's going on. She doesn't know whom to listen to, whom to believe, whom to trust and she gets confused at the end. The point is then that I, as a midwife, should be able to notice her confusion and help her.

The respondent above focuses more on the atmosphere created when postnatal women meet each other and exchange opinions regarding their experiences. This has a lot to do with more than one woman being in the same room. It worth's mentioning at this point that four beds is the maximum number in one room with two bed rooms being the vast majority. She mentions the fact that women might influence each other, not necessarily in a positive way.

It is highly likely that a woman who had a bad birth experience will pass the wrong message to the other women and they might assume that every experience is the same. A multiparous woman who, apart from a traumatic birth experience with her current or previous birth(s), had many problems with her baby as well might easily affect a first time mother. A first time mother has no experience of raising a baby and she relies a lot on other people's advice. She will probably be very anxious on how she is going to cope when she goes home and any negative thoughts might make her feel very anxious and drive her to panicking thoughts.

However, there might be a positive effect when women exchange experiences. They might help each other by giving advice on coping techniques for example. It might be very comforting for a woman to feel that there is a support system around her and that she is not the only person going through this. Especially for first time mothers it might prove very useful that she will learn tips regarding everyday things like feeding, sleeping or baby hygiene.

Nevertheless the role of the midwife is to ensure that a woman will take only positive thoughts when she leaves the hospital. In addition the midwife feels that it is essential to give the right advice so that the woman will have no conflicting ideas on any matter regarding herself or the baby. On a similar mode but from a different perspective the following respondent views the facility of a woman to express herself.

Vaso

No the woman will not open up. Because she thinks that the midwife is present, the doctor, a student and someone from the clinic next door. Whom do you want the woman to open up to? That's the bad thing in the hospital. There are too many people. It is the medical students that need training. It is the student midwife that needs to learn. It is the midwife who runs the clinic plus the doctor. There are too many people. It is very difficult for someone to open up in front of so many people. And you don't have the right to tell them not to be present. You can't. So, you stay within the formalities only. However, it is different in the afternoon clinic. The woman is alone with you in the room and she can talk to you. Of course when the husband is present she is not going to open up. But if I feel that she wants to talk to me alone I will find an excuse for the husband to leave the room for a while or something like that. Then she might open up.

The respondent here gives a different dimension of how the particular environment might shape a woman's attitude and how far she is going to express herself or not. The antenatal clinic that she is referring to, unlike the postnatal ward, has a different setting. It might be that no other woman is present during a consultation but many other health professionals are. As it is a teaching hospital, apart from the obstetrician and the midwife, medical, midwifery and sometimes nursing students are present. As it is clearly stated and it was observed by the researcher there was no consent taken from the woman for these students to be present or not.

Therefore it might be difficult for the woman to express herself because she most probably feels exposed towards this crowd and cannot speak her mind. She most likely believes that her confidentiality is threatened and that there is no relation of trust. It could be viewed as reasonable as it is not expected a relation of trust to be developed amongst a bunch of strange people within ten minutes. As an example someone could set that to the question if there are any kind of disorders running to you or your family, the woman might give a negative answer because she doesn't feel comfortable to reveal her personal life in front of everyone. Obviously it is to the woman's disadvantage that she cannot express herself and might conceal things which could determine her future care and her well-being in general.

Dimitra

No I don't think that the particular environment would affect women. I believe that the current setting is very pleasant, very clean. The only thing that might have affected them is if a few of them are in one room. This is something that doesn't happen very often. What I mean is that we try not to fill all the beds in the room. Of

course that depends on the general workload as it is now for example in the antenatal ward that they are completely full. I think that this is going to have a negative effect on a woman at risk...First of all the woman has no time to relax. When she manages to relax and her baby goes quiet, the other babies start. And imagine if there are three or four babies. Or when she wants to breastfeed and the person opposite has visitors. All these are negative aspects if the ward is very busy.

The respondent above separates the meaning of setting and environment. She clearly mentions that the setting per se is nice, pleasant and offers a lot of comfort to the woman's daily needs. It is definitely very important to be in a nice environment which is pleasant and clean and do not have to think about poor hygiene or to feel suffocated because it is an unpleasant room.

On the other hand she points out the disadvantage of the environment exists in the current setting. It is similar as all the other respondents and it concerns the presence of other people regardless of who they are. She believes that having more than one woman with her baby in the same room disturbs the tranquillity of the setting and the relaxed atmosphere a woman might wish after birth. It is possible that after an exhausting time a woman had during labour she wishes to have her space and care for her baby at her own peace. This might be disturbing and affect a woman's mood because she will not have sufficient rest. That may well influence her stamina towards herself or even her baby and the way she looks after it. Despite all these there was one respondent that saw the particular environment in a positive outlook.

Agathi

There are two or four beds. They all are en-suite for the women's comfort. I believe that we are working in a very nice environment.

She clearly states the comforts of the current setting for the women and how beneficial this is to their well being. At the same time she feels that the particular environment being so comfortable creates a nice working atmosphere as well. It shows how valuable it is for both women and staff to work or be nursed in a nice and comfortable setting. Someone could argue as well that this might boost the staff and initiate a more caring attitude.

7.1.2.2 Unlimited visiting times

Visitors are a subject that was mentioned by all the midwives interviewed. It was unanimous that the unlimited visiting times and number of visitors have an effect on the mother's well being. They commented on both the physical and psychological consequences the continuous presence of other people might have to both the staff and the women.

Katerina

A factor that worsens a woman's psychological health is the twenty four hours visiting time. I believe that a woman after delivery, normal or caesarean section, wishes her peace. She wants to feel the happiness, the smile, the crying of her own baby. She wants to look after her own newborn baby. We see the visitor, i.e. the mother or mother-in-law of the woman, replacing her in her role. 'You stay in bed and get some rest. We will bath the baby, feed it and change it'. That has the opposite effect. Because she feels that something that belongs to her and she was dreaming of for nine months, is taken away from her. And, by the way, how is she

going to learn? How is she going to see her gaps in the care needed? Visitors are damaging for the hospitals and the health care professionals. Imagine that you have visitors all day and night around you and for them to ask whatever they want.

The respondent above pays attention to the woman's psychological well being. It is clearly stated that the continuous presence and interference of other people could cause more problems than actually help the woman. Delivery in any form might be an exhausting procedure which requires the woman to rest and relax afterwards so she can fully recover. In addition it is a time that she needs in order to bond with her baby and enjoy for example the benefits of breastfeeding or skin to skin.

On the other hand there are many requirements that a newborn has and there are always new things to learn. It is without a doubt essential to have some form of support but it is equally important for the woman to become confident with the baby's care. Especially for the first time mothers it is essential that they look after their babies so they can explore the care of a newborn. This might help them on the long run when they go home and they will be more confident with basic skills such as feeding the baby and might make them less stressed.

However, the respondent is very critical on the effect unlimited visiting might have to the staff as well. It is assumed that visitors interfere a lot with their work and that causes friction. Staff are trying to provide care to their best ability and it might be frustrating if they have other people interfering with their plan of care and the advice they give. It is within the same region of thinking the following respondent replies.

Observation

I have been on the ward for most of the day. I noticed that this morning there were many people in front of the nursing station asking questions. They were all the mothers of the women asking the midwives questions that probably the mother should have asked (ie what to do with sore nipples). I have seen only one woman coming out of her room all day to ask something.

Efi

We are trying as much as we can to keep the visitors away and let the women to deal with their babies.... In the caesarean sections we can take care of the baby until she feels better. That is very difficult. We reach the point to argue with the visitors because we leave the women on her own. ...Visitors react very badly. Even when women are coming to ask as about breastfeeding or feeding in general there is always someone with them who wants to do his or her own thing. ...They don't give any chance to the women. That's what I want to say about the visiting times. Women need to have an initiative to look after their babies. Therefore, women would be more in contact with us and not with the visitors for some things that are concerning the baby, e.g. baby feeding. Even if you want to have a further talk with the woman on how she is feeding the baby or how she is changing it. Maybe you will be able to see how she reacts and you might be in a position to recognise if that woman needs special attention...You see, it is totally different when you are alone with the woman and the baby than when somebody else is present in the room with the woman.

It is apparent that the care of the newborn is once again reported as the major conflict issue between staff and visitors. Staff are worried that continuous presence of other people might cause more harm than help the situation. Women are not left alone to relax and enjoy their babies. Visitors are very persistent and they insist on their opinion without taking into consideration the experts' advice. This might lead to conflicting information and the mother might become even more confused than she already is. It is possibly inevitable then that maternal stress levels are going to rise and this might have an impact on the baby's care or the maternal psychological well being.

At the same time the staff are feeling undervalued because they cannot provide the course of care they wish and the adequate level required. They feel that women are not left to their own devices to explore the care of the newborn and that someone is always watching them. Midwives believe that if they were left alone with the woman they would have had more chance to give correct advice regarding care and address her needs. This would have probably helped the woman a lot as she would feel that she has got the right information and that could boost her confidence for the everyday care required when she leaves the hospital. Although the following respondent argues in the same mode regarding unlimited visiting, she also attempts to justify it.

Irene

If there were not so many visitors, you could treat the women even better. What's going on here with the visitors drives you mad. Especially in the afternoons. There is not enough staff, that is why. There is one midwife for four or five women. So, the visitor is going to help somehow. Because it is impossible to help all the women at the same time. There were periods that it was very busy and they were asking for too much. Yes the visitors are a bad influence. I believe that if it was one visitor per woman it would have been fine. But here we have from ten to twenty five visitors. And then you don't feel like going to help this woman. Only if she asks for your help.

The respondent focuses on the staff shortage and the drawback this has regarding visiting. It is because there is not enough staff to provide sufficient care that they might rely on a visitor to support the woman with whatever she needs on a practical level. Staff realises that it is impossible to provide exclusive care so they have to compromise with the visitors because they are the ones to help. However, there is always the argument that visitors overdo it and they gather in large numbers which

might have the opposite effect than helping the woman. The following respondent gives a totally different perspective on the effect unlimited visiting might have.

Voula

Simply said, the visitors are here for 24 hours. So, I believe that if a woman is troubled with something she is going to discuss it with her mother or her husband. It is not like other hospitals where women are alone. Where the visiting time is restricted and when women need something they will come to us. Here each woman has her own people and family to talk to. Many times her relatives might not allow her to talk to us. They don't want their personal problems to come out. But if she was alone I could call her in a private room and ask what was troubling her. But it is very difficult when she is in the room all day with someone else. It is very difficult for them to come to you and say something that is troubling them no matter how much they would like to do so.

For the respondent above the fact the woman cannot fully express herself is the most major drawback of the unlimited visiting. It is believed that the woman is overprotected by her own family and that whatever she needs, either practical or psychological, it is provided by them. This doesn't allow the woman to express her fears or worries to any member of staff so they can help her if there is a need to do so. This might prove to the woman's disadvantage because she might not get the appropriate support or referral. The lack of appropriate support might lead for the woman to develop different levels of anxiety and could affect her psychosomatic health. It is then rather inevitable that this is going to affect her and possibly the care provided to the newborn.

It is also mentioned that the family might not want a woman to express herself to any other person outside themselves. This is probably due to the mentality of the particular society which prefers the family problems to remain within the family. Nevertheless, this is a major topic of discussion which is covered extensively in a following section.

It is apparent from all the respondents above that unlimited visiting times could have major drawbacks for both the woman and the staff. The woman is affected by not having the chance to fully care for her baby or to express her problems. The staff feel undervalued being unable to provide the care they wish for, and that there might be cases who need help and they go completely undiagnosed.

7.1.3 Dissemination of information

Another topic that the vast majority reported was the lack of information. Thirteen out of seventeen midwives (n=17) reported that they have very limited and most of the time confusing information. Whereas the four remaining reported that they have no information regarding the area of postnatal depression. Mostly they commented on the limited sources of information and the ways they would like them to expand their professional knowledge.

7.1.3.1 Sources of information

It is apparent from the midwives comments that the sources of information regarding postnatal depression are limited. They referred mostly to information obtained during the undergraduate course and sporadic information gained from conferences or journal papers.

Dimitra

I couldn't say that there is enough information regarding this topic. Only what I know from the midwifery course. Anyway, it is something that we don't come across very often. Or we don't see it. I don't know.

Here the respondent refers to the knowledge obtained during her studies. She also mentions that postnatal depression is a topic that they don't come across very often and therefore their knowledge is restricted. It is apparent that the basic information regarding the topic was gained but was never put into practice due to the limitation of the cases. However, this could be seen from two different perspectives. Either that the information is there but not used because there are very limited cases or the information is not substantial and most case are misdiagnosed. Similarly the following respondent quoted:

Ntina

No, there is not enough information. And I personally have heard about it in some conferences or from some colleagues' papers or some journals. Nothing much but a few things here and there and not something concrete. You know, substantial. Not at least where I am working. Maybe I didn't care about it too much. Not really interested.

Here the respondent says that there is no substantial information on postnatal depression but it is up to the individual to obtain them from journal articles or any other source available. Therefore, it is mentioned that the personal interest regarding a topic plays an important role on the knowledge acquired. This might be because the focus is mostly on topics that the midwives face on their everyday practice as it is clearly stated from the following respondent.

Panagiota

Only from what I have heard around. Maybe it is because I used to work in the postnatal ward. There were some incidents that we suspected probably suffering from postnatal depression. For me it is very rare. The incidence is very low. I believe that there have to be some risk factors for this to happen. And of course I've heard about it in some conferences and some papers.

The respondent above probably mentions that because of the limited incidents of postnatal depression recorded in their hospital. However, there is a speculation that midwives who work on the postnatal ward might be on the privileged position on knowing more because it is an incident that might occur in that area. It could be hypothesised that their familiarity with postpartum haemorrhage for example is up to the highest standard just because it is very common and it could be considered as a fatal implication.

7.1.3.2 Reasons for lack of information

The theme emerged attempt to picture the reasons for lack of information regarding mental health issues following delivery. The respondents reported that personal negligence, inadequate staff and postnatal care are the main factors contribute to this.

In addition there were respondents who said that the existence of mental health problems after delivery is underestimated.

Ntina

I think that first of all it is our negligence. If someone wants to learn something he will find the way to do it. Nowadays with the advanced technology, the internet and through papers we ought to be better informed. But...[pause] heavy workload or the lack of staff in our department... Let me tell you this, for two months we were four people working shift pattern for ten days in a row because there was no people to cover. You know, off sick, maternity [pause]. As a result obtaining information becomes of secondary importance not only for this matter but for everything else as well.

It is reported that to obtain information is a personal responsibility for any member of staff who wishes to be up to date with the current knowledge. Existing forms of education as the internet or the journals offer a continuous source of information. However, the necessary time is required to search and read the information available. Lack of staff makes it very difficult for them to have any free time at work for further development. It becomes of secondary importance as the tasks need to be performed on a daily basis come first. This possibly brings the midwives in a position not being up to date with certain fields and therefore leaves gaps in women. Additionally, the midwives might be very tired after work and they are not in a position to dedicate much of their personal time for further education. There are some other respondents though who give slightly different opinion for the lack of knowledge.

Irene

The things that we talk about here have nothing to do with the woman's mental health. I believe that everything finishes when the woman gives birth and leaves the delivery suite. That's what we are mostly interested in, anyway. Nor we pay much attention to the postnatal women. That's for sure. When the delivery finishes we think that everything else has finished as well. We don't pay so much attention to the woman. We are waiting for the three days to pass for her to go home. I know it is bad. The most usual topics for discussion here are the postpartum haemorrhage, retained products and cervical tears. That's it. I know it is bad, very bad.

It is the way the postnatal care is performed that does not make any member of staff to wish to advance their knowledge regarding mental health issues. There is the perception that once safe delivery has been granted the shift of focus changes. This is probably due to the major responsibility staff has to achieve the highest health result for both the woman and the baby. In addition it is clear to them that the woman stays in hospital for three days and then she goes home. Their main duty is for the woman to be discharged with no health implications and therefore the focus is on topics such as the postpartum haemorrhage. It is admitted though that the existing mentality is wrong and should change. The following respondent expresses an additional reason why this mentality exists.

Natalia

Because no one admits that there are women who actually might suffer from this, especially the medical personnel. This is probably because their relationship is clearly client-doctor relationship and their time is clearly very limited. They want to finish as quickly as possible. To see only the results from any tests and that's all.

There are many people that do not acknowledge the existence of mental health problems after delivery. Denial might derive either from lack of reported cases or the

mentality that motherhood is a happy period in the woman's life. Amongst those people the medical personnel is included and therefore this affects the care provided. The time dedicated to women is limited and focuses on medical facts alone. Hence this denial does not create the need for the staff to be better informed and search the topic in depth.

The respondents tried to give some possible explanations as to why there is lack of information. Personal interest is of primary importance but heavy workload prohibits further development. A claim was made as far as the non existence of mental health issues is concerned. This is very important as it prohibits further development in certain topics. However, it declares the need for further research and professional development as it arises from the following category.

7.1.3.3 Professional development

It was a unanimous opinion (n=17) that further education and professional development is essential in order to advance the care provided and to benefit women to the maximum. It is mentioned that continuous education is not present at the moment but it would be highly beneficial if it was. There are suggestions on how training could be conducted in line with the resources available as well as the obstacles present. The following respondent gives an outline of these.

Olga

It would be very nice if the hospital, once or twice a month, did select suitable people from each department who can provide further education for the rest of the staff. That's for the patients benefit regarding better care and for our professional benefit as well. But since we cannot count on that we have to do something as midwives in our own private time. Because I can get a book to read before I go to bed and educate myself. But there are people that they don't have this 'luxury'. I might be lucky as I am not married and I don't have a family. So, I have as much time as I want. There are colleagues of mine though that they don't have the time. Why not then try to educate ourselves further during work and have a meeting once a week and analyse a topic? ... We are 25 to 30 midwives in this hospital. One of us could analyse a topic once in 15 days. ... Nevertheless, we have to advance our role even if it's with personal efforts only and provide ourselves with further education. Because we have to give correct, evidenced based information to women.

The respondent recognises the need for continuous development regarding all the aspects of midwifery care. This could be considered as essential to the midwives because it might ensure that they improve and update their skills and knowledge. This means that women are going to receive care up to the highest possible level. In addition midwives could be more confident because they will ensure that they offer care to the best of their abilities.

However, the possible challenge lies in how to keep midwives up-to-date, broaden their views and ensure women's benefit. Ways to achieve that are suggested and the primary suggestion focuses on study days. It is proposed for the hospital to identify suitable people to provide the staff with all the latest updates in as many topics concerning maternity care as possible. In addition constant effort on a personal level is probably required to achieve a higher degree of knowledge. Nonetheless, it might be difficult due to family or other kinds of commitment to achieve that. Because this might result to midwives not to obtain all the information required, the working

environment could try to ensure that a certain level of updated information is always provided. In that way all the midwives will have at least the same foundation and therefore they will provide a similar degree of care. It is on the same mode that the following respondent replies.

Vaso

Healthcare professionals should attend some seminars. We all need them. I believe that what we have learned during our studies is not enough, especially how to approach a labourer or a postnatal woman. They were not enough. Ok during your time at work you can do things yourself if you want. But they are not enough. Maybe we should do some psychology seminars. [pause] I don't know.

It is yet apparent that continuous update is essential in order to extend knowledge and upgrade patient care. Seminars are suggested as a means of achieving this and there is a specific suggestion for psychology ones. This might benefit midwives by teaching them different approaches towards women depending on their psychological state. This might be to the women's advantage because then care will probably be more focused on individual needs and they could have the attention required. In that way women who are more vulnerable might have the chance to express themselves and ask for adequate help.

The need for continuous education is declared. It is very important that midwives are up to date and be in a position to offer this knowledge to the women. This is going to benefit both staff and women as they would be ensured that correct information is

given and minimise anxiety levels. Midwives consider this as a central point of their role as it arises in the category follows.

7.1.4 The role of midwives as care providers

This theme emerged from the midwives' perception regarding their role as care providers. Seventeen (n=17) midwives reported their opinion and how they perceive their role. However, as it is apparent from the following quotes there is not a unanimous opinion and every midwife has her own views and perceives her role in a different way. Nevertheless there are some common points which formulate their beliefs and that is the importance of their role.

7.1.4.1 Self-perception of the midwives role

Midwives evaluate their role and express their feelings towards it. They give examples of what their role consists of and they try to prove the importance of it. To them their role is of primary importance within the maternity care setting and they do believe that they are in a primary position to help women in most aspects of their care.

Olga

The role of midwife is very important. It is very very important. Because the woman will stay two, three, or four days as a postnatal and she is going to be in direct contact with us. With the midwives. The woman is holding on to us to solve all her

queries. She might ask you the simplest thing for you but for her it might be difficult. You have to help her. No matter how simple or difficult the matter troubling her is. Our role is very important. We spend a lot of time with them on a daily basis. You are bonding with them. The woman doesn't see you like someone working there who is obliged to serve her. The woman sees you as one of her own people and she needs you. And she feels that you are the only person who can help her. That's why I believe that our role is very important.

It is rather obvious how the particular respondent refers with passion to the importance of the midwives role. It is believed that the midwife is the person closest to the woman during her stay in the hospital. She is always present and helps the woman with either her personal needs or the newborn care. The midwives during their shift have to be constantly present either on the wards or delivery suite. This probably reassures women that whatever happens to them there is a professional constantly present able to respond to their needs.

Women probably trust midwives because they know that they are knowledgeable and that they are always willing to help. In addition for many women childbirth is a new experience and they want someone who could probably understand what they have been through but they are also able to give a professional advice at the same time. Women probably need constant reassurance regarding their health and especially the care of the newborn without them being criticised. Midwives offer this reassurance and at the same time they come closer to women and probably make them feel comfortable to express themselves regardless of the topic. This is very important because midwives could possibly assess if there is a potential problem and make the appropriate referrals. It is on a similar mode that the following respondent expresses her opinion as well.

Stella

There are many times that we play the role of the confessor. This happens many times. For example women who suffer from domestic abuse. Many times they have confessed it to us, such as women whose baby was outside their marriage. You might think it is strange but they might reveal it to us. We reach a point where we bond with the labourers and we become one. Many times they reveal things such as cases that there are terminations that their parents or their husbands don't know about it. They trust us. There are things that we discover at that moment and they are not written in their history. It is very important... They might reveal things in order to show as their psychological state. Maybe that's the reason. Maybe it is one of the reasons that women might open up because those are things that you don't say easily. Maybe you never said them in all your life.

The respondent defines the role of the midwives as the 'confess man'. Here the respondent gives a completely different dimension to the role of midwives other than the health care provider. Women feel the need to reveal things that they most probably have not revealed to anybody else before. Driven from the examples given it is rather obvious that the revelations usually cover very important aspects of a woman's life and could have a major effect on it. The way women bond with their midwife during labour probably shows their need to feel completely secure and justify their psychological status. It is very important that women talk about all these things so in case of a complication the staff is aware and can deal with it accordingly. An example would be a pregnancy outside the current relationship so the midwife would be prepared to help if any social issues arise. That makes the woman more relaxed because she knows that if something happens someone trustful knows the truth and will act accordingly. In addition it might be useful for the midwife because she could be able to identify situations that might play an important role to the woman's mental health and propose additional help. However, it is in a completely different mode that she assesses the role of midwives.

Agathi

With the conditions we operate today our role is almost nonexistent. We cannot do many things. Maybe if we could operate on a different basis like some of us that met the woman here, to form a team and visit her at home once or twice postnatally. I believe that our role would have been better, more effective in order to understand a few things. Now we cannot do many things because as I explained to you the follow up is done by the obstetrician only. We see the woman suddenly as a unit, as a woman who comes to give birth, as a name.

The respondent gives a rather harsh description of the role of midwives as nonexistent. There is a disappointment expressed over the existing system where the follow up is done by the obstetricians and not the midwives. It is therefore believed that this underestimates the role of the midwives and does not allow their role to expand. There is a proposition for the midwives to formulate teams that would focus on postnatal visits. This might help the midwives to assess the conditions the woman leaves in and could possibly be an indication of a potential problem that needs referral. In addition the woman might feel closer to them and reveal them any personal aspects that could affect her health either physical or mental. The following respondent refers to the role of midwives with exactly the same definition as nonexistent.

The importance of the role of midwives is declared and how this role applies into practice. There is a general disappointment expressed as they feel that their role is underestimated. Midwives believe that they offer more in the woman's care if they had the chance to do so. However, they respect the current situation and they are trying to identify ways that could make them form a better relationship with the women.

7.1.4.2 Communication skills

Xrisa

On one hand they tend to ask you to show them how to bath the baby and take care of it in general. On the other hand they tell you to leave them alone. But of course you can use many tricks. When you go to bath the baby you could tell her 'why don't you come with me to keep me company'? In this way you are going to have the chance to talk to her and show her a few things e.g. care of the umbilical cord. It again depends on our mood. It is the human factor again. I believe that in this way we could have avoided many of these psychological incidents. It is the human factor. It is the conversation. To make them understand a few things and what is going on.

The respondent gives an example of women's attitude during their stay in the hospital and how midwives deal with it. According to the respondent women either they ask for help regarding their baby's care or they do not want to be disturbed. It is up to the individual midwife then how she is going to approach the woman and make her feel comfortable in order to open up. This could definitely be beneficial to the woman because in that way she might be able to open up and ask anything that worries her. This might clear woman's queries and make her feel less stressed about certain things and that could promote her mental health status. It is up to the midwives to identify ways to approach the woman and show her that she is there to answer her questions and help her regardless.

The human factor from the midwives' point of view plays an important role to that approach. The respondent mentions the midwives' mood and conversation as means of achieving it. Personal matters might affect the midwife's mood and she might not be in a position to approach the woman but she would rather perform tasks. This might have an impact on the woman's care as she would not feel comfortable to

express herself and have her questions answered. It is communication as well that the following respondent defines as a means of approaching the woman.

Observation

There is a woman coming to ask the midwife some information regarding her baby's feeding. She was very rude and she was shouting that no one has helped her. The midwife was trying to explain her that she was busy and asked her to calm down. The woman apologised and the midwife told her to go in the room and she would help her with the feeding.

Xenia

It depends on the midwife's style. Because, let's be honest, the doctors don't pay much attention. They come, they look at the woman and they go. It really depends on the midwife's style because if I go and speak nicely to a woman she will be relaxed with me. She will listen to me. But if I go and speak badly to her she will not trust me. It plays a very important role. She will not trust you which is the most important thing. It is a different thing to go into a room in a good mood. She will say that she had a nice girl with her. Because there are many times that women say: 'are you going to be with me? I want it to be you. Don't go'. That shows trust. She has a choice. But imagine that she is with someone who will shout at her. She will say 'oh my god what is this? I am going to have pain and fear and her on top of that as well'. It plays a very important role.

It is apparent that the midwife's approach is of primary importance in order for the woman to open up. It is clearly demonstrated that the nature of the doctors' work is different and therefore midwives play a very important role. Communication skills are the basis for a successful approach towards women according to the respondent's opinion. The focus is on the way the midwife is going to approach a woman and therefore make her feel comfortable or not. A woman during labour probably feels vulnerable and wishes as much support as possible. She is also probably aware that

she is going to spend many hours with the particular midwife and vice versa. Consequently a certain degree of bonding is required for both sides to feel relaxed. This might make the woman to feel more in control and reassured as she is aware that she can speak her mind and have all her questions answered.

An effective communication would probably promote and establish the woman – midwife relationship and hence it could help to provide and gather information. This might make the midwife more aware of the woman's needs and assess if further help is required. However, the midwives as any other member of staff should be aware of communication skills and minimise the effect their personal life might have at work.

Litsa

I would love for women to come and talk to me about their problems. I want to be in a position to give proper advice. But not with the information I have read myself or I have known from life experience. I would like to have appropriate information to be able to give proper advice to the woman. You have to find the right way to tell her to see a psychologist or a psychiatrist because if you want to say something to a woman you have to find the right way to say it. You have to find the right way to take her forward either to a psychologist or a psychiatrist because if you tell her straight forward she might say 'she thinks I am crazy'. Everything plays an important role. You have to be educated and be able to guide the woman and her to accept it. Because none of us wants to admit that we have neither a mental health problem nor a slight disorder. Hence a meeting with a psychologist could be the solution to the problem without the need for medication. That is something that we don't accept easily. That's what I would like.

The importance of passing information over is the main concern expressed. The midwife expresses the need to be able to communicate effectively with the woman and give her the correct information regarding any topic that worries her. Effective

communication lies on the fact that the midwife could give advice to the woman without offending her in any way. Mental health is a very sensitive area and needs careful management on how issues that arise are addressed. The midwife is concerned that if even she identifies risk factors she would not be able to alert the woman because she does not know how to pass over sensitive information. This is obviously damaging for the woman as she will not be aware of the need for a referral to a specialist. However, the woman might be more upset if the information passed ineffectively and therefore she will not ask for any further help.

Effective communication is identified of primary importance between the women and the midwives. It is the best way to elicit and provide information for both sides. Therefore, there is great need for communication skills to be covered in their educational curriculum. In this way they could feel more confident to perform practice and respond to the women's needs.

7.1.4.3 Interpersonal relationships

Most of the midwives referred to the interpersonal relationships that should develop between themselves and the women. They find it essential that in order to elicit information from women regarding any problems they have to build a very good relationship with them. However, they do understand that it is necessary for this to happen that both sides should make the effort.

Katerina

As far as the pregnancy follow up is concerned women who have no history of behavioural problems, I would say that they have no particular problem. Because they face pregnancy with a good mood and they like you to talk to them about it, to joke about it...Their mood is lifted. Now, as far as the people with a history of depression is concerned... It's true that you see them very tight and I don't think that the system in public health care hospitals helps them. This kind of people you ought to see them either at the beginning or at the end of the clinic sessions. In this way we are going to give them one or more hour to get familiar with us and open up. Like that we give them the chance to open up and get answers in every question they might have, and believe me they are quite a few. You have to behave like a brother or a sister like a mother, a father, a husband because, they feel rejected and we are their only hope.

The respondent above talks about how women face pregnancy and how their mood affects them in a positive or a negative way. According to the midwife women of positive attitude appear to have an optimistic approach towards pregnancy and it might be an indication that there is no mental health history. However, there is the other side where women might have a history of depression. They are believed to have a more conservative attitude and possibly view pregnancy in a negative way. This is where the health professionals come and by adopting the right behaviour they are trying to help them.

It is considered of high importance the way the health care professionals and the system as a whole face mental health problems. It is essential that the necessary time is given to the women to primarily bond with the staff and as a result to raise their concerns. This might prove to be a key issue for both the staff and the women. The staff might feel that by distributing the time according to the patients' needs they would be in a position to offer individualised care. In addition the staff might have

the initiative to act in a friendlier way to the woman's benefit. The women might feel that they are amongst a 'family' environment and that they will feel embraced and have continuous support. However, the following respondent extends it regarding both staff and women.

Efi

From there on is a matter of character as well. Because some people are more reserved and some others more open. And if you are reserved you become even more. But even if someone is an open person when you come here and you see some unknown people for a few days only, it is very difficult to open up. Because she doesn't know you and she cannot trust you [pause]. If you have a problem and you come to us for specific things then it might be that by chance we might develop a better relationship. But then again they won't come easily. You have to go and see if they need something. Especially if their baby is on the neonatal unit they don't relax no matter what you say..... I believe that it depends on the woman behaviour as well. I mean if there is a negative behaviour from the beginning [pause] it makes the atmosphere heavy and you don't pay so much attention. If there is someone who is an open person and she wants to talk to you and she is polite, you are going to focus on her a bit more....The same thing is for women as well. These things are interrelated.

The respondent starts with a comment concerning the different characters staff might come across. There are either open or reserved characters and it depends which type of character a woman has it might affect her attitude. There is an emphasis given to the fact that even if a woman is 'open' it is very difficult to express herself to people that she does not know very well. This could be translated that women would like to have a certain degree of bonding with some members of staff in order to reveal more personal information. It is trust the feeling women would like to have towards staff and this could only be achieved by knowing certain members of staff for a long period of time. Continuous care then is probably what is speculated by the

respondent by having a midwife who follows up a woman from the beginning of the pregnancy to the end.

However, the most interesting comment is the staff's perspective over their behaviour depending on the woman's character. It is said that the staff are affected from the way a woman is going to approach them. This is possibly to the more extroverted women's advantage as they make the staff feel comfortable and makes it easier to talk to them. On the other hand, midwives might bypass introverted women without giving them the chance to express potential problems. The midwives might think like that because they might feel that they have no right to intervene in anyone's personal life if it is not asked to do so. In addition they know that it takes time to make someone open time and possibly the fact that their time is limited it makes it very difficult to achieve. The fact that this account has been recognised by the midwives could make them more sceptical and equally distribute their focus on all women. It is the good interpersonal relationship with the women the way the next respondent approaches the topic.

Stella

I am trying to have a rather calm relationship with the women. I always try to answer their queries. And I am trying to answer their queries in a way for them to feel that whatever I say is a fact. I don't want to confuse women or make them have doubts. And if it is something that I don't know I am going to find out and let them know. All this of course applies to the vast majority of women. Because there are some women who need a special approach either to be more assertive or humorous. It depends on the woman. But I always try to have a good relationship with the women, a trusting relationship of course. They need to trust you. I mean whatever you tell to be the truth. Then they will come and ask you more things. They will trust you more than other people. This doesn't mean that the other people lack knowledge.

Maybe they don't have the right approach to communicate knowledge. That is whatever I say is a fact.

The focus of the respondent above is personalised care. She believes that every woman has a different character and she should be approached on a different way depending on it. This means that the midwives should have a woman centred approach and assess women's needs on an individual basis. That is beneficial for women as their needs will not possibly go unrecognised. The other point that it is considered is the trusting relationship the midwives should have with the women and how this could be achieved. It is believed that by giving correct information which is evidenced based it makes women more confident and inevitably less stressed. It is very important for the midwives to have updated information and the necessary skills to transfer it across to women. In this way probably both sides will be satisfied as midwives would have done their duty and women would have secure knowledge.

It is apparent that a good interpersonal relationship between the women and the midwives is essential. It helps the women to express their needs and the midwives to offer an individualised care. This complies with the perspective to focus more on the women's needs on a personalised basis rather than performing tasks. It could help to identify underlying disorders and could make women more confident and less anxious when they go home and will have no midwifery support.

7.1.5 Midwives perception on causes of mental health problems following childbirth

One category emerged from the data was the midwives' views over what they perceive as causes of postnatal depression. They tried to give their own explanation of what might contribute to its incidence. Fourteen (n=14) out of seventeen (n=17) midwives expressed their thoughts where the other four (n=4) preferred not to refer to the subject. The themes emerged from the interviews showing as possible causes the fact that the focus is on physical care and the way postnatal care is held as well as that the care is mostly delivered by obstetricians and not midwives.

7. 1.5.1 Personal accounts of midwives experiences

The researcher here tried to elicit as much information as possible regarding midwives experience with postnatal depression. Only two (n=2) out of seventeen (n=17) reported that they have experienced an incident regarding mental health following childbirth during their career.

Litsa

As far as the postnatal depression is concerned, I witnessed a case when I was working on delivery suite. It occurred exactly after delivery. As I said I was on delivery suite at the time and not on the postnatal ward. She was under special care because she had expressed suicidal thoughts. She was going out in the balcony with the baby in her arms and things like that. I really remember this case because I was looking after her during labour. She was talking nonsense after delivery. The moment her baby was delivered she started talking nonsense.

The respondent refers to an incident happened exactly after delivery. The woman started showing symptoms after delivery and according to the respondent they worsen the immediate postnatal days. Suicidal thoughts were reported from the woman and her actions were clearly indicating the need for further follow up. It is reassuring that appropriate care provided for the woman to recover. Although this is a severe episode of mental health problems it does alert the staff to be aware of these kinds of situations. The following respondent describes a severe episode as well and how it was faced.

Natalia

Well, it was four or five years after I started working. It was a lady that after she delivered she was completely out of space and time. She didn't know where she was or why she was there. She didn't want to see the baby. She believed that her husband is not her husband but his twin brother. I know that she was under psychiatric care. It took her some time to recover.

This is a very severe case described where the woman reached the stage of hallucinations. Close follow up from the psychiatric department was required. Effective and efficient intervention played an important role to the woman's recovery. Both incidents reported show that severe cases occurred during the hospital stay receive appropriate care and therefore had a good outcome. However, the respondents were unaware if any risk factors were identified during the antenatal period. The first incident described could be recalled from the following respondent.

Panagiota

I have never seen anyone with postnatal depression. Only once I have heard an incident on the postnatal ward. They had a woman who didn't want her baby at all.

She didn't recognise it. She didn't recognise anyone. There was a psychologist involved and many others. They have said to take the baby away from the mother. They suggested for someone to be with her at all times because she had suicidal thoughts. But myself I have never seen one.

The respondent has not experienced an incident herself but she could remember one heard her colleagues to talk about. It is rather obvious that the incidents reported are limited. However, it is encouraging that immediate help and appropriate referral was offered. This means that once a mental health problem is suspected proper action is taken. Hence if risk factors could be identified for all women during pregnancy or postnatally the referrals required could be done and have a positive outcome. Therefore, it is the next theme that attempts to explain why this is not happening on a routinely.

7.1.5.2 Main focus on physical care

The total number of midwives interviewed reported that the focus during pregnancy and after delivery is mainly on physical care. There is a number of tasks to be performed on an everyday basis that they do allow enough time for the midwives to explore any further issues with women. In addition it is a general demand that the medical care should be at the highest standards and this shifts the focus from everything else.

Agathi

First of all I take a handover. I want to know what is going on. Then I am going to prepare the medicine, to be ready. Then I do a round to see all the postnatal women. To do this I usually choose the time that we distribute the thermometers. Even though

taking the temperature is not my job but the nurses'. But I want to do it myself because I can find out about potential problems that women might have such as breastfeeding or anything else. Because when the doctors will do a round I will be fully informed. But it gives me a chance to interact with the women. Then I will do whatever else needs to be done in the department. Maybe I will have a new woman. I will need to settle problems with her or the baby. I believe this is not enough time for the women to open up. Most of them stay with us for two to three days. Then we don't have the time ourselves to care about every woman individually. Unless there is a specific incident that needs special attention. Then you are going to focus your care on her.

It is apparent that routine tasks take priority during the midwives shift. It is of primary importance to ensure that both women and babies are good in their health and that there will be no problems at discharge. However, there is a round done by the midwife to ensure that all women are well and if there is a need to focus more in any of them. It is though speculated that the round is focused on physical problems that a woman might face herself or if she has any problems with the baby. The time spend with the woman on an individual basis is restricted and therefore there is a limitation as to what it could be discussed.

Efi

We start our departmental routine with babies' baths. We see if there is any problems with the babies and if they are all right. Then we revise our handover. Then we have the doctors round. We prepare the discharges and we do the PKU test for the babies. We give bed baths to the women who need it. We check the intravenous drugs and commence new ones if needed. We complete the fluid charts. We do the drugs round. We check the lochia and if the uterus is well contracted. We pay special attention to really sick women who require further care than the everyday routine care. During the afternoon shifts or night, things are slightly better, not that busy. We do the drugs round, hand out the thermometers for temperature check and wash the caesarean sections... We take care of the newly arrived babies. We show feeding techniques and things like that. And then we help when the mothers report any problem with the baby's feeding or any other problem the mother might have with the baby mainly.

The respondent here is trying to describe a typical day on the postnatal ward. There is an attempt to have a step by step routine as this unfolds throughout the day. There are many tasks to be performed and there is a special attention regarding babies feeding. The midwives once again want to ensure that both women and babies are well and that when they go home women will be quite confident regarding baby's care. This could be considered as positive as by having a certain degree of confidence women would be less stressed and that might contribute to their mental health well being. The reason being is that they could get into a routine easier and this might help them to organise their time and feel more relaxed. On the other hand, the staff is feeling confident that they have done everything to their power to ensure the physical health of both mothers and babies. This possibly implies with the hospital's care standards that no physical health implications should arise after women leave the hospital. This mentality it is not on the postnatal ward alone but in other departments as well.

Natasha

First of all about pregnancy. What they should take care of or if they are able to go to work. They care a lot about their appearance. What they should be eating, or how to dress or if they can colour their hair. These kinds of questions they ask initially. Husbands usually ask if they can have sex. When we take the history they might say if there is a problem concerning their mental health. If they will say it. Because I have noted that some women don't say it to me when I take the history but they say it later on to the doctor. Unfortunately, the woman comes here first for the doctor and then for the midwife.

Similarly:

katerina

The routine in the obstetrics antenatal clinic is the monthly pregnancy follow up. Means, the woman will come and we'll see which week she is in, we will see what tests we need to do, her vital signs and we'll listen to the foetal heart. There is the cardiotocography department as well where we do the ECTG's which are a routine after the 36th week.

The respondents above are trying to give an account of the care provided in the antenatal period on a routine basis. There is an emphasis from both staff and women on the maternal and foetal physical well being. There are specific tests needed to be done routinely during pregnancy and the staff wants to guarantee they will run smoothly. One of the respondents mentions some of the questions women would ask during their visit and their hesitancy to talk about any kind of mental health related problem. This might be a drawback for women as many factors could go unnoticed and that could obstruct any further referral.

It is noted that physical health is the main concern not only from staff but from women as well. There is an attempt to demonstrate where the focus of care is and if that covers women's concerns. This probably demonstrates a more generalised concept of maternal care and the dimensions it is centred. However, it might be that a holistic approach towards women should be adopted in order to cover every aspect of both physical and mental well being.

7.1.5.3 Follow up in every stage of pregnancy by obstetricians rather than midwives

The current theme emerged after the total number of midwives mentioned it as the most important factor that could make mental health problems go undiagnosed and mistreated. It is believed that the follow up in pregnancy by obstetricians does not give women the chance to talk about their personal problems and express hidden thoughts and anxieties. On the other hand there are some accounts of how women might experience the current care scheme.

Vaso

Women don't come to talk about this kind of problems. The woman disappears after the delivery. She has a contact with the obstetrician forty days after delivery and then she is gone. She has no further contact with the midwife. The woman places the obstetrician above everyone. Of course there are some women who acknowledge that, and they say that 'I am going to find my midwife to talk to'. She helped me. She was with me during labour. The doctor came at the last minute. But if you ask her who delivered you she is going to say Mr so and so. She will not say I had a midwife as well. She might say it later. Unfortunately the doctor is above everyone for the woman.

Women in the Greek hospitals stay for three days after a normal delivery and five after a caesarean section. After that they have their six weeks postnatal check which is done by an obstetrician. The respondent here refers to the current system that the women leave the hospital and have no contact with the health professionals until forty days later. It is mentioned that women come to the hospital to have a safe delivery and no other matters are discussed during their stay.

According to the respondent it is the doctor who is above everything for the woman and the person she trusts the most. This could be explained because the doctor is the only person she sees during pregnancy and therefore she appreciates all his efforts. Midwives feel underestimated and that they think they could offer much more to the woman if they had the chance to do so. The following respondent agrees with this perception as well.

Ntina

I couldn't say anything because here the whole follow up in pregnancy is done exclusively by the obstetrician and us, as midwives, don't do much. Apart from four to five midwives down the antenatal clinic who might see the woman during pregnancy, the rest of us will not know her. No one here knows anything about this woman. I am telling you this is because the follow up in pregnancy is done exclusively by the obstetrician. I don't know if the obstetricians are in a position to understand something or how much time they dedicate to every woman. I believe they dedicate limited amount of time to the woman to be in a position to care about the woman's psychological health as well. Unless there are risk factors and the woman knows it.

The current system regarding care in pregnancy is characterised as medically orientated. The time they dedicate to every woman is limited and the care offered is focused mostly on the physical well being. There is an assumption that mental health is neglected unless there is a known history. This might make the women more vulnerable in the sense that they could not express themselves and mental health problems would go unnoticed. The midwives feel that they would like to know more about the woman's history so they would be in a position to offer their help. The fact that they are not as actively involved to the woman's care as much as they would like

to be might make them feel that they are not in a position to offer adequate care. It is this matter the following respondent is trying to explain as well.

Olga

I totally believe that there are doctors who pay attention to the woman's psychological health as well. I couldn't be certain that they don't pay attention at all. I think that an obstetrician is interested a lot in the fact that everything should go well during pregnancy, labour and postnatally. He is interested in vital things. Things like for neither the woman nor the baby to die. That's why under the pressure to preserve the woman's and the baby's life, they make the mistake not to pay attention to the woman's psychological health. He will try to encourage her with a few words but he will not go deeply. Now, why is the woman asking this from the doctor and not from the midwife? Because in her own eyes the doctor is her God, her saviour. He is the one who is going to run to save her if something happens. He is the one that her life and her baby's life depend upon. She respects the midwife but not as deeply as she respects the doctor.

The current respondent is trying to portray the situation as it is. There is an attempt to justify the present system and to explain why things work in this way. Doctors are the ones who care primarily for the woman's and baby's lives. It is not said that they place mental health in a second spectrum but they face tremendous pressure to perform their abilities to the maximum and not have any fatalities. In fact is what is requested from the woman before anything else. Women want primarily to leave the hospital with both themselves and their baby safe. That is probably the reason why women see the doctors as life saviours.

Midwives on the other hand feel that they could fill this gap and help the woman with other aspects of care rather than their physical health. Maybe they could spend

more time with the woman and make her comfortable so she could open up and be in a position to identify if a woman is at risk.

The medical model is criticised and the role of the midwives regarding the care during pregnancy or postnatally is expressed. It is assumed that the current system and the way it works do not support women to its full potential. Certain members of staff feel underestimated and that they are not given the chance to offer care on an individual basis. Hence it is probably believed that a holistic approach could be applied which would improve the care provided.

7.1.5.4 Postnatal care

The way postnatal care is performed under the current system is on top of the range for the midwives as to why mental health is neglected. As it was explained earlier on women stay in the hospital for three days following a normal delivery and five days after a caesarean section. There are no home visits and the woman could contact the obstetrician if she has any problems.

Xenia

Because we don't have home visits. This means that we see them for three days or five if they had a caesarean section and then the women disappear. We might see them again for their next child. That is our contact with women. There is nothing further than that. Neither before there is no contact with the women or after unless one of them is our friend. Only in such a case we will know if something has happened before, during or after pregnancy. Myself I see that my friends trust me. And they are going to call me for their worries before and after. And there are times that they call me to ask things because they think 'let's not call the doctor for that. Let me call...who's my friend'.

The lack of home visits is the first thing the respondent mentions. Midwives find it as the most important component of the postnatal care. They speculate that after women leave the hospital nobody knows how they are doing and if they need support. They can always call the obstetrician but as it is said it is not happening on a regular basis unless it is a related health problem. This probably happens because women distinguish the roles of health professionals and probably think that after they leave the hospital the role of that department has finished. According to the respondent though there are other women who want to talk to someone and they do not want to disturb the obstetrician for that. So, if they might call the midwife if they have a personal relationship. It is not easy for the woman to open up to anyone even if she thinks she needs support. That is why she will trust the midwife if she knows her very well. It is a similar opinion the following respondent expresses.

Tonia

I am sorry I am interrupting you. But there is no contact. When a woman gives birth she stays in the hospital for three days on a normal delivery or five days following a caesarean section. After that the women disappear. I would like if there was a way for the women to be able to contact the midwives even if it was for the first twenty eight postnatal days as it is stated by the law and able to find the midwife and talk to her. Because it is different between women. And it would have been much better if it was a midwife whom she had during pregnancy. But unfortunately this doesn't exist. And I do believe that many of my colleagues would like it because after that we don't see the women any more. How are they doing, how are they coping, how this maternal instinct developed, nobody knows. And this process is not easy at all. It is not a matter of magic. We don't touch them with a magic wand and their maternal instinct comes out. It needs a lot of work.

The current system is discussed again by the respondent. The length of the postnatal stay and the lack of support after she leaves the department are also mentioned. The

respondent here states that although by law a twenty eight days contact with the midwife could be achieved this is not happening. Home visits are not a current practice from the midwives neither the postnatal nor the antenatal period. This is not a choice but it is to do with the policies exist. The drawback is that many women feel more comfortable to talk to a woman than a male obstetrician. Women might see the midwife closer to them and find it easier to open up. It could be easier for them to ask their opinion and ask for further support if required. On the other hand midwives themselves would like to see if all these women who leave the hospital are coping at home and they have adjusted with the new situation in their lives. However, there is a different opinion expressed from the following respondent regarding the topic.

Stella

I do believe that if the woman gives birth she doesn't need my help any more. She needs the help of her family environment. I believe the most appropriate person to help his wife is her husband neither her mother, or her brother, nor anyone else, neither myself as a midwife. I have to support her that moment [labour] when she is stressed both physically and mentally. After that moment the stress disappears. She sees that her child is well and she is happy. She feels fine in herself and she wants to see her own people. Therefore, she doesn't need me. The woman that needs me is the woman that has a problem, the one that still feels stressed. And for her to be still stressed means that she has a problem either mental or physical.

The respondent here states that the woman when she goes home she does not need any further support from the midwives. She believes that her husband and her environment play the most important role. The woman needs the midwife more during her hospital stay and especially during delivery. It is considered to be the most stressful moment. After delivery and given that both mother and baby are healthy, the family environment should form the support system. It could be assumed that the

husband and the family environment are the people who spend most of the time with the woman and therefore they should be the primary source of support. Nevertheless, the midwives should be there if they needed to help the woman.

Home visits are the main point most of the midwives referred to. It is important for the woman to have the choice to speak to someone and take advice at all times. Talking to a midwife might be seen as talking to a friend and could encourage women to express themselves and ask for further assistance. Additionally midwives could identify risk factors and make appropriate referrals. Nonetheless, family plays the most important role and they are the main supporters. Midwives perceptions are inclined with their views on the effects of postnatal depression as it is mentioned in the category follows.

7.1.6 Midwives perceptions on effects of postnatal depression

7.1.6.1 Stigma

One of the most interesting findings arose from the data was the issue of stigma that was mentioned from the vast majority of the midwives. It is considered to be a significant effect that accompanies any kind of mental health problem. It is the fear of stigma in the particular society that prohibits most women to reveal any issue related to their mental health. The researcher believes that the quotes referred to the particular matter are characteristic of the mentality exists in the region.

Xrisa

The only person a woman could talk to if she has a problem is the midwife. It happened to me that women who had a problem they revealed it first to me and then to their doctor. However, they do not talk about very serious problems to anyone. I am under the impression that there were many women who had problems and they never said anything. I have looked up their history in their files and there was nothing written. It's a matter of mentality. The region of Epirus is a closed society and that's the mentality here. We don't announce our problem to the others. We hide it as well as we can. Let it be there. And we try to solve it as well as we can, if possible, and with all the consequences that arise from the fact that we are hiding it.

The respondent here comments on the mentality in the particular region of Greece. She describes it as a 'closed society' and mentions the restrictions this brings in certain aspects. Mental health is portrayed as a very important issue that is not wide in public. Serious problems that might worry the woman should not be revealed to anyone but they should rather keep them to themselves. The midwife reveals that the women are inclined to talk to them if any concerns. However, it is mentioned that when it comes to serious problems they prefer not to reveal them. It is also said that there are many women with mental health problems that they do not mention them to their history when they were asked. From the midwifery point of view this is very important because there are serious information missing which might affect the woman's health and the care given. If a woman is using antidepressants for example and that is not revealed it could affect the pregnancy management. It is exactly on the same mode that the following respondent replies.

Olga

The social environment plays a very important role. The society that we live here in is a much closed society with numerous taboos I hope it is not true what I believe but I am afraid it is. People are trying to hide incidents within the family. They want to

show everyone that there is nothing wrong and everything is fine and that the woman's behaviour is a bit strange due to the life changes with the baby's arrival. Generally speaking, I don't think that the particular society is facing up to such a situation as well as it should be.

The local society and its mentality are once again to blame for women being unable to express themselves. There is a tendency from the family to hide her problems and does not allow other people to find out about them. A reason for this might be the fact that people outside the family all they want to is to gossip about them and there is no real intention of helping them. This shows the close family relations in the region and how protective it could be to its members. However, on the other hand it prohibits its members from asking help when it is essential and could really benefit them. Many women could go undiagnosed regarding mental health problems following delivery and face all the possible consequences. The following response is in line with the current one.

Natalia

I believe that it is the surroundings that influence a woman a lot. This is a conservative society. People are afraid in case anyone else knew. There are many times that not even the husbands or the husbands families know problems they might have had prior to their pregnancy. Psychological problems or mental disorders especially, they don't want their husband's social environment to find out and sometimes even the husband himself. I do believe that what they are afraid the most is whether we will keep the information disclosed or not. I believe that this is it.

Women are afraid to express themselves because they do not wish to reveal any kind of personal information. They probably feel threatened that if other people know their problems they might harm them because is such a taboo in the local society.

According to the midwife there are many women that they do disclose this kind of information not even to their husbands. It is highly likely that the effects of stigmatization overtake the need to deal with it. It is very important that women are afraid that confidentiality in these matters might not be kept if they talk to any midwife. This seems a serious allegation as it contradicts the code of practice all members of staff should work under. The issue of trust is brought to light as well as the issue of continuous care so the woman will know the midwife very well and she will not feel threatened in any way. However, it is the next respondent who gives a broader explanation to the topic discussed.

Voula

*I cannot interfere in other peoples' lives. I cannot, especially, if that person will not ask for my help. If that person comes to me I will then interfere but [pause] [hesitant] I cannot offer significant help because I am going to be in between the two sides. On the one side are the woman's relatives and on the other side is the woman herself. I do believe that if you take it seriously you might harm the woman, because the woman is going to stay here for three days only. After that she is going to go. I believe that the problem is going to continue being there in a grater scale. No one wishes to announce their problems especially if they are personal ones. I really believe that I could harm the woman. The woman stays here for a few days only and when she goes home things might get worse. I believe that this is the reason that women don't speak out about their personal problems. You might see that they don't even share them with their friends, let alone with us. The society here in **Ioannina** and similar areas are tightly nit. Women are very careful to say something that bothers them because they are afraid that everyone else might find out. It is not like Athens or Thessalonica that women are more liberal. It is different when you live in a big city. In that case they know that whatever they say won't be heard. In this city if someone tells something it is highly possible that the next day half of the city will know about it.*

The midwife here expresses the hesitancy on her behalf to take responsibility over personal problems that a woman might face. If the woman herself will not ask for

help the midwife seems detached and she does not feel she could help the woman. There is an assumption that interference could make things worse. That is because after the woman leaves the hospital there is no further follow up from any midwife and the problems will only accumulate. In addition, the midwife does not want to bring the woman in difficult position by asking her personal questions when she does not wish to share this information.

Apart from the conservative society the issue that arises again is that of trust. It is very important for the woman to know that any kind of information revealed will remain confidential. The woman possibly feels that due to lack of confidentiality her personal information will be revealed and she will be judged from her environment and the local society in general. Therefore, it is very important for the staff to apply confidentiality and refer the woman when necessary under secrecy if that is the woman's wish.

A conservative local society and its mentality appear to be a major factor that prohibits women from seeking help regarding mental health problems. This mentality has embodied in all forms of relationships and there is no real trust amongst women and health care professionals. There is so much fear of stigmatization that women do not open up in case confidentiality is breached. However, as it occurs from the data it is the family that plays a very important role in that society and the mentality is held as it shows in the following theme.

7.1.6.2 The role of the family

It is very interesting that the role of the family has arisen as theme during the interviews. However, it is not surprising for the researcher as Greece is a family orientated country. Most of the midwives have mentioned the role of the 'grandmother' and by that they mean the mother of the woman. As it is apparent from the interviews this has advantages and disadvantages for the woman. It is rather apparent from the interviews that the grandmothers play an important role as they would like to have an active involvement to their daughter's care.

Vaso

I believe that only few pay attention to the woman after the delivery. Everyone pays attention to the baby. The woman comes as a second priority. Everyone asks first how the baby is and then how is the woman. And if a woman says that she has this kind of problem they will say that she wants to be pampered. The environment's critique is very tough. Why are you like that? Why are you stressed? Why are you crying? Is it only you that has ever become a mother? Even if she worries about the baby or even if she tells the husband that she can't take it anymore. I believe that the woman's environment is very harsh. They are very tough when criticising her. They pay all their attention on whether the baby is eating or gaining weight. The woman comes second most of the times.

The arrival of a newborn definitely brings happiness to the family and is of primary importance. The main focus shifts now from the woman to the baby and the woman might feel neglected. There is always the assumption that a new mother should be happy and all her thoughts should be towards the baby. Her environment thinks that there is nothing to prohibit her happiness and that everything else is excuses to draw attention. In this way any symptoms a woman might present will not go unnoticed but they would probably be misinterpreted. Her environment does not realise that any

changes to the woman's behaviour could lead to serious mental health problems and she might not be able to cope.

Efi

It is the mentality that exists here. It is only a few women that will stand up and say that they will look after the baby. Naturally, the women who had caesarean find it difficult to look after their babies properly. They need somebody with them most of the times. However, women who had a normal delivery don't need somebody else with them. But it is the local mentality that 'you don't know or you can't or you need to rest'. They believe that the fact that you delivered is extreme and that now you have to relax. They feel that you are not well. They don't believe that the normal delivery is something natural and after that you feel all right. In this way women find their comfort zone and they don't look after the baby themselves.

The respondent here comments about the existing mentality regarding aspects of care after delivery. The family environment and the grandmothers in particular take over from the mother as far as the care of the baby is concerned. There is an assumption that a woman following normal delivery is not in a position to look after her baby and needs constant support. The local mentality is the one to blame for this behaviour according to the respondent. The family environment is overprotecting the woman and possibly limits her abilities to look after the baby. Women might be flattered from the family's interest and take advantage of it to rest. On the other hand this might prove to the woman's disadvantage. Primarily when women do not spend long time alone with the baby might affect their bonding with it. Secondly, when they go home they will have to look after the baby mostly themselves and they might get stressed because they do not feel confident enough. It is this mentality that seems to worry the other midwives as well.

Litsa

The grandmothers get the upper hand over the women. The women are a bit spoiled as well, so it is not easy for them to look after the baby immediately or to take matters in their own hands. And of course there are women who are or feel weak, especially the ones following a caesarean section. Therefore, the grandmothers get the upper hand. They say 'rest, don't move, you are in pain' and they put themselves in charge of looking after the baby, to feed it, to change it or even to ask questions. This is of course overprotection, because the grandmothers feel that their life has a meaning again. They feel that they become mothers again and they don't let the women neither express their queries, nor to take matters in their own hands. It is much better when the women are alone than when they are having somebody with them. They are different. It is more likely that they trust you because there is no other opinion to listen to. We are certainly not doubted as much from the mothers as from the grandmothers. They tell you the classic 'we brought up children as well'. I know that she brought up children but that was twenty five, thirty or forty years ago. There is no relation with the past and the present.

The respondent here although she comments on the local mentality that was mentioned earlier on she is seeing it from a different perspective. The grandmothers perceive the coming of the newborn as giving a new meaning to their lives. As the respondent says it makes them live motherhood second time around. It also probably gives them the chance to offer and feel useful. All the respondents refer to the local mentality that children are above everything and the parents would do everything to help them. Hence the phrases 'stay, don't move...' possibly derive from that over worrying and overprotective feeling.

The staff on the other hand feels that this mentality is a drawback for the woman and does not allow her independence as a new mother. Especially when the grandmothers interfere and they ask questions regarding both baby and maternal care. It does not permit to the women to express themselves and sometimes it might be confusing because they have too many opinions to listen to. This might be stressful as the

woman does not know which advice to follow and she could end up doing the completely wrong thing. In addition the staff might feel underestimated and that they are not in a position to offer adequate care.

The current section presented the categories and themes emerged from the data obtained from the midwives. It reflects their perceptions over the current system within the maternity settings and echoes their views over postnatal depression. The researcher attempted to illustrate the findings without discussing them with references to the existing literature. This will be attempted separately in the discussion chapter with the data obtained from the obstetricians. The data emerged from the obstetricians is going to be presented analytically in the following section.

7.2 Data obtained from the obstetricians

Categories	Themes
1 Dissemination of information	1.1 Inadequate education 1.2 Main focus on the clinical aspects of pregnancy
2 Obstetricians perceptions on postnatal depression (PND)	2.1 Cases of PND 2.2 Onset of PND 2.3 Views of the obstetricians on

	dealing with PND
3 The obstetricians view of their role	3.1 Self perception as clinical providers 3.2 Interpersonal relationships and communication 3.3 The involvement of psychologists in obstetrics

Table 5: Data obtained from the obstetricians interviews

7.2.1 Dissemination of information

One of the categories recorded was the dissemination of information. The vast majority of the obstetricians reported that there is limited information regarding mental health following pregnancy. On the other hand the curriculum during their medical training covers extensively all complications that might arise and how to deal with them.

7.2.1.1 Inadequate education

All the obstetricians acknowledged the fact that due to the minimal education received over mental health matters they are not in a position neither to recognize it nor to deal with it. They feel very confident to face any complication that arises in terms of physical health which is their main focus. The following respondent expresses this idea.

Dr Stephanos

As I already told you, there is no adequate education. Nevertheless, there is something else as well. We consider as ideal topics for a dissertation, or a presentation or even to study, topics that we come across on a regular basis. When it comes to subjects that we don't know about we wonder why learn more about these matters. We face them as 'what kind of topic is this'? We do believe that when it comes to a topic that we don't know about is not worth it...The second thing is that this topic is not covered extensively in our curriculum. If it was we could always have in mind these kinds of problems and how we should handle them. I do believe that this is the main point...So, we should incorporate more of these in our curriculum. We will thus be better informed and able to assess if there is a need for improvement.

It is believed that there is no real interest to focus on topics that are coming across on a regular basis. The concepts discussed or presented are the ones that the doctors are familiar with and they have medical implications. It would for example more useful to them to extensively discuss postpartum haemorrhage or foetal heart monitoring. Maybe that is because they feel responsible for the woman and baby's lives and they want to be updated with all the topics surrounding their physical health. However, the respondent mentions that most of the staff are not ready to leave their comfort zone and deal with topics that are out of it. He explains this by not having the initiative to depart from the medical model. This might be to both obstetricians and women's disadvantage as obstetricians will not be in a position to identify potential risk factors and make the appropriate referrals. It is education that the next respondent focuses as well.

Dr Antonis

I do believe, that in Greece there is no obstetrician, or a midwife, or even a nurse that is so well trained to either identify or support a postnatal woman who is in such a situation. Look, think about it, how many of our university lecturers know enough

about adult psychology to teach us? I do believe that the education of most of the health professionals regarding psychology is from minimal to nonexistent. Neither we nor our teachers know about adult psychology. Therefore, we do not know anything about this entire chapter that has to do with human psychology.

The respondent here observes that psychology is an underestimated field and does not have the appropriate attention required. The fact that the curriculum of most health professionals does not cover psychology matters extensively puts them in a position where they do not know how to deal with mental health problems. Women and other patients are not viewed as a whole but the focus is on certain aspects of their illness. It is possibly assumed that once the health problem is solved that the patient has no other needs. However, the following respondent gives a different notion to the topic under question.

Dr Giannis

I do believe that the obstetricians in Greece are not adequately trained to identify any form of depression let alone postnatal depression. First of all the obstetricians cannot assess this illness, and also this illness is part of the postpartum period, which is a period with lots of complications, these are the main problems... However, I don't think that specific medical knowledge is required in this kind of cases. All that is needed is the knowledge of understanding [pause and hesitation]. You need the woman to fully open up to her doctor which in Greece, not only for reasons concerning the doctor but for reasons concerning the woman and her environment, is not happening.

The limited education regarding mental health is once again acknowledged. The fact that the priority is given to the physical health is mentioned. Postpartum period may have implications for the woman such as haemorrhage or infections and they obstetricians want to be assured that first of they will be treated and secondly no

further implications will arise. These matters occupy the obstetricians mind and the focus is constantly shifted away from psychological problems that might exist.

Nonetheless, the respondent here believes that there is no real need for extensive knowledge regarding mental health problems during or after pregnancy. He thinks that a personal approach is far more important. The key is to have open conversations with the woman and make her feel comfortable to express all her worries so the doctor will be in a position to help her. The drawback is that these kinds of conversations are very rarely held possibly because neither the woman nor the obstetrician is ready for it. The following theme that arose from the data describes the tendency to focus on clinical aspects of pregnancy.

7.2.1.2 Main focus on the clinical aspects of pregnancy

The everyday shift routine is mostly described in this theme. The time is limited and the obstetricians are primarily trying to ensure that the pregnancy is going well and both mother and baby are safe.

Dr Giorgos

In the antenatal ward where I am based now, the main focus is to perform ultrasound scans. We need to see how the pregnancy is progressing. Other things are to check if a woman needs clerking or to perform all the clinical tests. If there is a labourer we need to assess if she is in active labour so she can go to the delivery suite. These are mainly our duties throughout the day. It involves more clinical tests and examinations than discussion with the woman [pause]. When a woman comes to give birth or for any other kind of problem we should pay a bit more attention to the woman herself not only her pregnancy pathology. We should assess if the woman has been affected by her pregnancy and see if it is her first or second pregnancy, and if it

is her first what kind of advantages or disadvantages she might face. Unfortunately due to lack of time we cannot do any of these things.

The respondent is trying to give an account of a typical day in the antenatal ward. It is a very important ward as women with problems during pregnancy are looked after plus women in early labour. For this reason the focus is shifted mainly to the physical aspects of care. In that particular phase even women although they are vulnerable they are mostly worried about their health or the baby. Therefore, the obstetricians having limited time as well. They are trying to minimise the women's worries by offering their best to tackle the health problems. However, they do recognise that more attention should be paid to the mental health well being and every woman should be assessed on an individual basis. It is on the same mode that the following respondent replies

Dr Leonidas

A visit includes, you know, the classical routine. It includes the review of all the blood results, the assessment of the weight, the blood pressure etc, or if there is a kidney problem, or a drug prescription, or if there is a need for a scan. This is what it is included in a visit. How long it takes, it depends. The results review and medicine prescription lasts about ten minutes. If there is a need for a scan then it lasts longer. Of course it depends on the questions the woman wants to ask. There are some women who come with a list of questions and there are others who just come for a prescription. We inform them about the medication they can take, the hygiene they should follow, the exercise they are allowed to do and any other problems they might face. For the breastfeeding women we advise them to continue. We tell them how to take care of their babies and if there is any kind of problem during the postnatal period to call us so we can solve it.

The routine visit of an antenatal or postnatal woman is described. The topics include all the clinical aspects of care and the aim is to reduce any potential health

implication. The time dedicated is around ten to fifteen minutes but it depends on the woman and what queries she might have. The same is for the postnatal women where advice is given regarding baby feeding and personal care. There is no indication that more personal matters are discussed or if the woman has the chance to open up. However, the following respondent attempts to explain the reasons of the care given.

Dr Dimitris

You know that there are incidents that the woman is followed up by a psychiatrist and the obstetrician doesn't know about it? And the obstetrician doesn't know about it because he never had the time to discuss with the woman because we see the woman as a clinical incident. What is wrong with her, has she got abdominal pain? Is the baby all right? Is the foetal heart rate normal? Is there normal growth? Is the amniotic fluid within normal parameters? You know all these things that surround pregnancy. Nevertheless, her inner world remains a secret to her doctor or to any other doctor that is involved in her care during pregnancy.

The respondent here gives an example of women not revealing essential information regarding their mental status. He refers to incidents that women were under psychiatric care and they did not report it to their history. This means that it is probably women themselves who do not want certain details of their lives to be revealed. The reasons being might be because they do not want to be stigmatised or they might feel the role of the obstetrician is different. Women might think that the obstetrician is there for their safety and anything else belongs to other specialties. Hence this way of thinking gives minimal chances to the obstetrician to interfere and help the woman.

7.2.2 Obstetricians perceptions on Postnatal Depression

The current category refers to the obstetricians views towards postnatal depression. The obstetricians on the contrary to midwives had more experiences with mental health problems following pregnancy. Some of them they had to deal with such problems and they presented their personal experience. They were also inclined to give possible explanations on the causes of postnatal depression and give their opinion on how and if they would help.

7.2.2.1 Cases of Postnatal depression

The theme presented here talks about incidents of mental health problems during the postpartum period experienced by the obstetricians. Half of the obstetricians interviewed had faced an incidence at least once during their career.

Dr Sotiris

I delivered that girl on her third baby. I think she had some problems after her second pregnancy. She was presented with some signs of postnatal depression after her third childbirth. The first signs were shown during her stay on the delivery suite. There was no psychologist at the time in the psychiatric department. She was seen by the psychiatrists and they gave her some support but no medication. The woman left and for fifteen to twenty days she was all right. Then we had to advise her to give up breastfeeding. She was completely distant towards her newborn plus her other two children...[pause]. She disappeared. I don't know what happened. Of course, I will always think that I should have investigated things a bit further during pregnancy especially given her history, but...

The woman presented with signs of postnatal depression after delivery and had psychiatric intervention. There was a need to give up breastfeeding because there was not mother –infant interaction and there were probably afraid that the baby was

not having its daily requirements. It is evident that there was immediate intervention when signs presented. The positive thing is that no medication required and support by psychiatrists helped her to recover. However, the obstetrician was unaware of the progress after the woman left the hospital. Nevertheless, the obstetrician confessed that despite the woman's history from her second pregnancy no further investigation was done. It might be that if the woman had support throughout the pregnancy maybe there was a better outcome. A similar incident is reported by the following respondent.

Dr Lefteris

There was a girl that had no particular symptoms during pregnancy neither as a postnatal here with us. I found out about it by chance from her sister. She told me that she was treated in the psychiatric clinic. But honestly she did not present anything here while she was in the postnatal ward. Yes, I found out that after she went home a few days later that she stayed for some time period in the psychiatric ward. Whatever she developed appeared after her three days stay with us. That is the amount of time for the postnatal stay. She developed the problem before day forty within the postnatal period, somewhere around day fifteen to twenty. She was on antidepressant treatment. I went to see her and we spoke a little bit but nothing...[pause] I saw her again after four weeks and she was much better. She was wondering what had happened to her and that she never expected something like that to happen. Neither did I, but everything went well.

The obstetrician here refers to an incident happened fifteen to twenty days after the woman left the hospital. She was under psychiatric care and she was treated with antidepressants. The signs presented are according to the literature typical of postnatal depression. However, no risk factors were identified neither during the antenatal period or the postnatal stay in the hospital. It has been mentioned before that no home visits exist in the current system and therefore nothing could be done

by the obstetrician. It is apparent that there might be a need for home visits to be established so women could have an immediate contact with a health professional in case signs and symptoms of postnatal depression are developed. It is on a similar mode the following respondent replies.

Dr Iakovos

We have had a case recently in our department. [pause] It was not postnatal depression exactly there were some elements of depression during pregnancy and they developed during the postnatal period. They were treated successfully by our hospital psychologists. We saw the woman forty to fifty days later and she was much better than she was when she was here with us.

The respondent talks about a woman who presented with signs of depression without the development of postnatal depression. The early intervention from the psychologists has possibly prevented further advancement of depression. The woman was seen again by the obstetricians for her six weeks postnatal check and she was feeling much better. It is positive then for the woman that symptoms were recognised and better prognosis was established.

All the incidents described had good prognosis and that was due to the early intervention from either the psychiatric department or the psychologists. The need to identify risk factors is presented as well as the necessity to assess them and intervene as early as possible. Hence the following theme emerged regarding the onset of postnatal depression.

7.2.2.2 Onset of Postnatal Depression

Most of the obstetricians here attempt to give an account of the factors that might contribute to the onset of postnatal depression. They are talking about what they feel it could affect women and lead to unpleasant side effects regarding their mental health status.

Pregnancy is a very difficult thing especially to young women and primiparas. If there is any pathological problem the clinical tests will show it but she might have another kind of problem within her family environment. Maybe she doesn't want this pregnancy. Maybe she doesn't have enough support from her husband which is considered of primary importance during pregnancy. Maybe it is the fact that the husband cannot accept that he has to sexually abstain for some time and this creates problems to the family. All these issues might make a woman unwelcoming towards her pregnancy or to turn against her baby later on. I am sure there are such cases. The woman might feel that the foetus was responsible for all these. For example that the husband cheated on her. She may feel that the baby is responsible for such things, although this is clearly not the case.

The respondent talks about the relationship a woman has with her partner and how this could affect her psychology and the way she views her current pregnancy. Her husband might not accept the fact that he has to make certain sacrifices or he might not be as supportive as the women would wish him to be. Guiltiness is the feeling the woman might develop because she could feel that her pregnancy is responsible for her relationship crisis and all the effects follow. According to the literature the relationship with partner is one of the main causes that might lead to postnatal depression. Having a baby is a transitory stage to the woman's life and support from her partner is of primary importance in order to be able to succeed in her new role. In addition to these is the woman's character another obstetrician identifies as a risk factor.

Dr Giannis

Primary signs during pregnancy might be a woman's reserved character and the way she reacts to her environment. This reserved and negative outlook might reach a point where she may reject the whole pregnancy thing, especially after the second trimester, when she can feel her baby. I do believe that all these are basic elements that might indicate that this woman could develop depression during her postnatal period.

Negative and attitude and reserved character are the two main characteristics that could lead a woman to develop signs of depression. It is the way she reacts to any kind of pressures coming from her environment and the difficulties she might face play a very important role to her well being. Negative or positive attitude towards pregnancy is suggested as the primary key sign should be observed by the staff so they can assess if the woman could need further attention or not. It is the woman's attitude the next respondent focuses as well.

Dr Stratos

Many women complain that they have a little pain here and there and we don't pay any attention to their psychological state and what we offer is simply reassurance that this pain is nothing. And sometime this little pain is not objective but subjective. It might be there but it might not be as well. You have to understand that pregnancy on one hand might be something completely natural but on the other hand is a period with a lot of changes for the woman, with her hormones, or her psychology or with her body. Especially the body changes', speaking as a woman, is what brings a major change to the woman psycho synthesis. She sees so many changes on herself.

The attitude that the woman faces pregnancy focuses on the body changes this brings. The body changes during pregnancy and that might affect the woman psychology and the way she faces the whole situation. Hormonal changes might have

an effect on her behaviour and she might feel more vulnerable. It is this kind of changes the respondent is suggesting that more attention should be given and constant advice and help to be available.

Relationship with partner, attitude, hormonal changes and body image are the main factors the respondents believe are risks factors that could lead to postnatal depression or any generally affect a woman's psychology during pregnancy and afterwards. The health professionals should be there to support the woman during this period and offer guidance throughout it. However, the following theme emerged was the willing of the obstetricians to deal with postnatal depression.

7.2.2.3 Views of the obstetricians' on dealing with Postnatal Depression

In the current theme the respondents are expressing their beliefs on how achievable it would be to manage mental health problems following delivery. Most of the respondents referred to the individual willingness to pay attention to the woman's mental well being.

Dr Sotiris

I don't give any advice on a routine basis. Although if I see a woman that is more reserved and I identify some symptoms that might lead to puerperal psychosis then I will definitely do so. There is a small number of women which, during their stay in the postnatal ward, I have recommended to be reviewed by a psychologist. But it is a very limited number. To be honest, personally I don't pay much attention. I know I should be doing the opposite. I do recognise that this is a mistake. Therefore, I believe that in Greece we are not so advanced in terms of dealing with mental health problems following delivery.

The respondent here although he says he has referred women in the past to the appropriate services he declares that his personal involvement is generally limited. The obstetricians are aware of the mental health problems that might arise after delivery and especially puerperal psychosis. Appropriate referrals are made and special attention is given when required. On the other hand obstetricians might be reluctant to deal with these kinds of problems and this probably lies on their focus in the woman and baby's well being. It lies again that physical health is of primary important and probably there is a need to pay more attention on mental health as well. The following respondent gives a similar account.

Dr Antonis

I think that the problems someone has in his/her personal life concern only himself/herself. To a certain extent they might concern their [named] doctor if it is a health problem. They definitely do not concern anyone else... I think in a public hospital the relationship between the named doctor and the woman is very specific and understood from both sides. It is like a contract. The contract says that I want you to deliver me a healthy baby and myself to be healthy as well. 'This is the reason that I might thank you or not later on'. She means that. My role as a doctor primarily is to deliver a healthy baby. That's it, end of story... Here the doctor cannot do anything apart from reassuring the woman that everything is going to be all right with pregnancy. I don't think he could offer something more substantial. The only think he could do is to boost her confidence up a little bit but this ends the day the woman is discharged from the hospital.

The respondent here refers to the 'contract' between the woman and her doctor. The woman herself the only thing she requires is a safe delivery and a healthy baby. There is nothing else further than that she is asking from her doctor. It is the woman herself who does not wish any further involvement in her private life. Therefore, she might bring the obstetrician in a position where he is reserved and cannot interfere.

This might be to the woman's disadvantage as either incidents might go undetected or worsen if untreated. However, it is evident what the priority is in the woman's life while pregnant and how this could affect her way of thinking.

Dr Dimitris

During the daily ward round we see if there is a problem or not. We see some signs that she is not well for some reason and we try to empathise with her. Today, for example, we had a woman who was ten days post surgical with raised temperature and she was climbing up the wall. She was really upset. We tried to calm her down in a very sweet manner. I think that every conscious gynaecologist ...[pause] Ah, I need to tell that I was not her personal doctor I was just on call for the day. I think with a smile and a nice word you can positively approach her. The woman always feels delighted when you explain her everything. The same thing happens when you are very pleasant. These two things might lead to satisfaction. And I don't think personally that I would have any kind of reservations not to help her. On the contrary I believe that I will do my best to help her.

The doctors feel that they are in a position to realise if a woman is under stress and if she needs further support. The way a woman is approach could make a difference to her mood. A nice smile and a positive approach could make the woman to open up and express her worries. In addition the woman feels less stressed when everything is explained properly and she is given the time to fully understand any situation arose. The willingness of the staff and effective communication skills are the key elements for the woman and the doctor to form such a relationship and suggest any interventions if required.

7.2.3 The obstetricians' view of their role

The category emerged is referred to the obstetrician's perception over their role, the bond is formed with the woman based on trust and good interpersonal relationship. In addition most of the obstetricians interviewed talked about how women perceive the obstetrician's role and what they want from the services provided.

7.2.3.1 Self perception as clinical providers

The respondents refer to their role as medical personnel and clinical providers. They feel that according to the women's wishes their role is limited to their obstetric duties and no further interventions required from them. However, the respondents reported that they would like to do their best if the woman asked for it.

Dr Stephanos

My personal belief is that our role should change completely at least as the follow up of pregnancy is concerned. To me the role of an obstetrician and gynaecologist is more complex. It is a role that will approach the patient and will clearly understand the patient. On the other hand of course his expert opinion will definitely lead to the correct diagnosis and treatment. It is a combination of three things, the medical part, the diagnosis and the therapy. And of course a more personal approach with the patient might lead to safer result in the long run.

The respondent refers to the three components that are forming the obstetrician's view over their role. The diagnosis and the therapy are of primary importance followed by the personal approach which could benefit the woman on a long term basis. The role of the obstetrician is to understand the woman's needs on an individual basis and try to provide the best care available. The reason being is

possibly because there is a realisation that a holistic approach combines both mental and physical well being. However, the following respondent expresses a different approach regarding the topic.

Dr Leonidas

I think that the problem stems from the fact the woman doesn't allow this to happen because she distinguishes the roles. She believes that the obstetrician is there for the baby. She has the baby on the one side and her problems on the other. And I think that is where the problem lies. She does not realise that her problems might be related to pregnancy. She distinguishes those things. Therefore, she is going to discuss with the obstetrician about her pregnancy and the baby. And you clearly see that by asking a woman what the most important thing is for her during pregnancy. She is going to answer that it is the scan. That is what she is going to tell you... She doesn't care about herself. The only thing she cares is her baby. Therefore, by paying all the attention to the baby she doesn't want to express any other problem.

The respondent gives the woman's perspective and how she views the role of the obstetrician. The woman when she is pregnant the only thing she thinks of is her baby. That is the probably the reason where the only thing she demands from the obstetrician is a safe delivery. She distinguishes the roles of every health professional and makes it clear which one is for what. Obviously, this is to her disadvantaged because she does not allow herself to express all her worries and get the help required. On the other hand she restricts the obstetrician to open up any kind of discussion and offer further services. Another point of view is given by a different respondent.

Dr Sotiris

The young in age doctor might be more stressed himself but he will pay more attention to the woman. A young doctor, apart from the fact that he pays more attention to the woman, knows what to ask her. This is more likely because all these might be of a recent personal experience. Of course experience matters a lot. The

older doctor will most probably have the experience but he will not have the time. When there are so many women to see of course the time is clearly very limited.

It is the age and experience that matter a lot according to the respondent. It is believed that a young doctor would pay more attention to the woman than an experienced one. It is possible that a young doctor will be more enthusiastic and he would be inclined to pay more attention to the woman and her needs on an individual basis. In addition recent personal experience could make him more sensitive. Experience counts a lot in order to recognise certain signs but heavy workload would bring limited time to spend with each and every woman.

Different perspectives were given regarding the obstetrician's views over their role and what is expected from them. It is clear that women usually differentiate the roles of health professional and demand certain things from them that apply to their specialty. Safe delivery of the baby and good maternal health is to the women the most positive outcome and they rely to the obstetricians for that. However, the obstetricians are trying all their best to satisfy the woman's needs and would like to have the chance to offer a holistic approach to their care. This chance they aim to obtain by building a trusting relationship with the woman and communicate with her effectively.

7.2.3.2 Interpersonal relationships and communication

Most of the respondents referred to a good personal relationship with the women and that would make them feel comfortable and open up. There are some factors

mentioned against it as the lack of time or issues of confidentiality. The staff's character and the willingness to help is an additional factor mentioned from a few of the obstetricians.

Dr Giorgos

I think the staffs' character plays a very important role. Either we talk about the doctor or the receptionist, the midwife or the nurse. There are some people who are more sensitive and they will give their best. And then you have the typical civil servants who don't care about anyone and anything. I might be lucky and have you, a nice and sensitive midwife, and you will help me with everything. However, I might have someone else that if I ask her help with breastfeeding I will not understand a thing because she will say everything quickly, uninterestingly and formally. The same happens with the doctors of course.

Communication skills and eagerness to perform are the two main characteristics the respondent refers to. It is believed that is very important how the staff approaches the woman and how comfortable they make her feel. The woman could feel safer and less stressed if she has someone who explains things thoroughly and is making sure that she clearly understands everything. This gives her the chance to ask her queries without feeling unwelcomed. It also contributes to her experience from pregnancy and delivery and how pleasant this was. A slightly different approach is given by some other respondents.

Dr Stratos

We all want to help the woman but we don't know how to approach her. One way is to dedicate a lot of time. Another way is to become more familiar with the woman. Nevertheless, it is difficult for a woman to talk. She will not mention any personal problem. It is very difficult for the obstetrician to suspect something. No, no, I don't mean that. I mean it is very difficult for the obstetrician to talk with a woman about more sensitive matters unless she mentions them herself. What I mean is that if there

is a family problem there is no way that the woman will mention a word. It might be a matter of pride. She might not feel safe enough to talk about it. Ok, she might feel safe enough to be examined by the obstetrician, ...she might feel safe to get undressed in front of the obstetrician, but she might not trust him enough to talk about her family problems. She might think that there is no confidentiality.

Time, familiarity and the issue of confidentiality are mentioned here as restricting factors for a woman to open up. There are two ways suggested to approach the woman. The first is for the doctor to dedicate as much time as possible and the second to build up a close relationship with the woman. However, it is mentioned that despite one of the two ways is used women would open up. Personal matters are considered as sensitive matters and women would try to hide them very well and it becomes difficult for a third party to realise if there is something wrong. Confidentiality is the issue that is raised as a barrier for the woman to confess any mental health issues. It is an issue that was raised on the midwives' data and has to do with the local mentality. Here it could be assumed that it is probably the same reason and the woman does not feel safe. It is exactly the same mentality that the next respondent describes.

Dr Dimitris

After many years of working experience he [the doctor] can understand if there is something wrong with some women. But he has to have the time to deal with it. Although he might notice something, he might not have the time to investigate it further especially if the woman doesn't ask for it. We are talking about serious problems of course. Because there are some minor problems that will never be discussed or the woman will not tell you the truth. This is because there is no interpersonal relationship. She will tell you that she has a headache even if she has another psychological problem. She will express her problem with somatic pain. We had examples of women who were physically abused by their husbands and they came to the hospital with just abdominal pain. The problem though was not the

abdominal pain. There was no problem or contractions. The problem was that they were physically abused by their husbands.

A very serious incident is described here with women who had been physically abused but they never confessed it. Women most possibly do not want other people to know that their relationship is not going well because they are afraid that they might be stigmatised or criticised. On the other hand obstetricians are in a difficult position because they cannot interfere to degree they would like to. Experienced obstetricians can realise if a woman is not well psychologically but they declare that nothing could be done unless asked to interfere. The problem lies that there is no interpersonal relationship where trust could be build and both sides to feel comfortable to open up.

The current theme reinforces the importance of having a trusting relationship amongst the staff and the women. It is a case of uncovering serious incidents and for the staff to offer the best help available. In order to create this relationship both sides need to trust each other and confidentiality should be kept to the maximum. However, obstetricians realise that the existing mentality is not easy to change and therefore they suggest the involvement of experts as it is suggested in the following theme.

7.2.3.3 The involvement of psychologists in obstetrics

Obstetricians many times feel that the help they could provide is limited and they would like the involvement of psychologists as experts in the field. That is the suggestion of the one third of the obstetricians interviewed. They are convinced that

an affiliation with the psychologists could give women the opportunity to express their concerns and have the care required.

Dr Antonis

It is very difficult for the obstetrician or the midwife to take up the psychologist's role. Neither the obstetrician nor the midwife could take up the psychologist's role even if they wanted it badly. The psychologist will say things differently. It might be because when the woman comes to us we will tell her to have a scan, to have blood tests and the woman probably takes it as granted that that was it...[pause]. From there on even if there is something else inside her that makes her struggle she will not say a word about it. But if she goes to somebody else where the discussion will be 'what is your problem', this would be different.

The distinction of the roles is presented here by the respondent as a means for a woman not to open up. The woman has in her mind that there are certain reasons that she goes to see the obstetrician. It is believed that a psychologist given his expertise would know how to approach the woman and make her express herself. Routine overtakes other matters which they go undetected because there is no time and no rapport between the woman and the doctor. Given the chance the woman would probably open up and speak for her struggles and she could receive the appropriate directions. Then staff could be aware if any risk factors exist and if this woman would need further care during the postnatal period. It has to do with the roles distinction that the following respondent lies on.

Dr Sotiris

There must be a psychologist not only in our specialty but in every other one. There is no communication with the woman. And this is not because the doctor doesn't

want it. You have to approach her on a different way. You have to tell her from the beginning to leave the baby aside and focus on her problems. This is something that obstetrician cannot do. That is because if a woman comes and I tell leave the baby now and let's talk about your problems she will leave straightaway. She will say 'what am I doing here? I came for my baby. I am not interested in other things'. That is where the problem lies. She distinguishes that her child is a different thing from anything else.

It is recognised that effective communication is the key to a woman – doctor relationship. Apart from the medical point of view though the obstetricians feel that involvement from other specialties required to form this relationship correctly. It is assumed that the psychologist knows how to approach the woman and make her feel comfortable. It is a skill that the obstetricians do not have. Therefore, the combination of different specialities could formulate the team required so the woman would have a complete follow up during pregnancy. In this way the obstetricians believe that every specialty could perform their role and clear distinctions could then be justified. It is on a similar mode the next respondent replies.

Dr Lefteris

When you identify a problem you just inform the psychologists to give you more information about the specific incident. Without you being able to deal with the incident as a psychologist would, or talk about it with her. These women might be particular, so it is better to inform the psychiatrist. He or she will be better off to deal with it than any obstetrician even if he is adequately trained. I think that the obstetricians' role is to identify a situation and that is where he should focus. As far as the therapy is concerned the psychologists or the psychiatrists should have the primary role.

The respondent here gives a clear role to the obstetrician which is the identification of the problem but not the solution. He is not the expert to deal with these kinds of

situations in depth and therefore the involvement of mental health experts is required. Even if he has some degree of expertise on how to approach the woman he thinks that the appropriate referral will bring the results desired.

Mental health experts and especially psychologists are suggested by the obstetricians to be part of the pregnancy follow up. It is essential for women to have the choice to receive holistic care during pregnancy and afterwards and not to neglect certain aspects of it. Psychologists might be in a position to identify risk factors and arrange a care plan that would benefit women to minimize the consequences of mental health problems during the postnatal period.

7.3 Suggestions on how to improve care

The final section of the findings chapter combines the midwives' and the obstetricians' suggestions on how to improve the quality of maternity care regarding postnatal depression. The reason they are presented together is because the researcher felt that it was not necessary to form two separate categories and present the results in that way. Both midwives and obstetricians felt that to improve communication and to formulate a trusting relationship, are the two major requirements to improve care.

Tonia

I have suggested to give women the number of a help line where they could ask whatever they feel. It could operate for two hours a day and I would know that for two hours I have to stay and expect phone calls from any woman. It would be nice for her to call me and me to inform her about everything, even if she can take her baby out depending on the weather. That is what I suggest for the beginning, a help line where every woman could have access. I think that something like that could work very well because all women want to phone and ask queries. I do believe that this line could be very beneficial.

The respondent here gives some practical advice in order to improve the postnatal care. An open telephone line is suggested where women could call at certain times and ask their queries. The midwife here believes that many women would welcome it because they all have queries but no one to ask. She believes that could minimise woman's stress levels on everyday things by having an expert opinion. The example given is whether the woman could take the baby out or not at any weather. There are so many other questions that have to do with everyday things that the woman needs the reassurance that she is doing well. However, it is not for the researcher to judge if this idea is achievable or not on a practical level. It is communication as well one of the suggestions the following respondent focuses on.

Xrisa

I believe that from the very first minute that the woman has her pregnancy test done till forty days after delivery, she needs a continuous collaboration between the midwife, the obstetrician and the psychologist during this entire period of time. You have to know the woman. You have to talk to the woman and develop a trusting relationship. This is one aspect that could be improved. Another aspect is to improve the present building. It is not very difficult to install dimmer switches or to have more windows. It would be nice to leave the woman to go outside her delivery room and talk to her husband. I don't think that the baby's life is at risk if I won't listen to the foetal heart beat for five minutes. All these things can change.

Team work is suggested by the respondent amongst three specialties, the midwives, the obstetricians and the psychologists. In this way the woman will feel fully covered in any aspect concerning her pregnancy. Both physical and mental well being is reassured in this way. In addition team work could help to clearly distinguish the roles of every specialty. This could help them to focus on their role and offer the best services available depending on their skills.

Apart from that the midwife suggests changes in the current environment on delivery suite. She proposes some alterations which could make the woman to feel calmer during delivery and comfortable with the unknown environment. The support from the partner is essential for the woman during labour. It is suggested then that a degree of contact could help the women to relax and feel reassured that she is been supported. It is worth mentioning here that not all husbands are allowed to be present during labour unless they attended the antenatal classes. It is a policy from the hospital who wants to protect the partners who are not familiar with the labour process. It is the familiarity of the environment that is suggested next.

Panagiota

It would be nice if every woman could visit the delivery suite prior to delivery so that she becomes familiar with the environment and the faces in there. This is something that many women ask me when they come for an ECTG: 'could you please show me where am I going to give birth'. 'Could you please show me some of the midwives'? They want to familiarise themselves with the particular environment and with us as well. There are women who have to stay in the hospital for two or three months during their pregnancy. These women behave much better because at the end they know almost everyone of us and they feel very comfortable. I want the environment to become more friendly and let women to come freely and look around if it is possible and ask their questions and queries and get advice.

The respondent suggests for the woman to familiarise themselves with the hospital environment and the delivery suite in particular. It could make them feel comfortable and relaxed. It would be easier for them during the labour process to suddenly go to a familiar setting than somewhere that they have never been before. It is very stressful especially for primiparas where they will have to face the unknown of the labour experience in a completely strange environment. In addition they might feel shy to ask for things or to express themselves because they see so many unknown faces. That is the reason for the comment over women who have stayed in the hospital for a while. They feel very familiar with the place and the staff and they are more relaxed with them. All this might give them a better birth experience and they could avoid getting traumatised. Interpersonal relationship and a pleasant environment is the focus of the obstetricians on their suggestions.

Dr Dimitris

I haven't got much experience with the particular topic [pause]. I think that every woman should have her named personal obstetrician. In this way the doctor will have time for her and the hospital won't feel so distant. A woman comes and her antenatal follow up is by one doctor, then she would be delivered by somebody else and somebody else will follow her up during the postnatal period. I do believe that an interpersonal relationship is the one which is going to improve care and the trust in the obstetrician. If there is no trust we cannot have the whole picture surrounding the woman.

A named doctor who follows the woman from the beginning of the pregnancy to the end is the suggestion from the current respondent. Building a trusting relationship is the main concept for the woman to open up and express herself. It is the same for the doctor as he gets familiar with the woman and he is in a position to understand things

and ask her questions. Given the local mentality over mental health issues, if there is a trusting relationship the health professional would be in a better position to suggest a referral if needed. It is the same mode of effective communication that the following obstetrician lays his suggestions.

Dr Iakovos

I would suggest more psychology lessons and our behavior to be [pause]. We need to be as close as possible to the woman. We need to solve every query she has. She needs to know that we are with her in every problem that she faces and to create a more pleasant environment if we can... What I mean is that me, personally, I cannot make the room more pleasant neither change the curtains nor the colors on the wall. What I could change is to enter the room with a smile and create a cheerful atmosphere for the woman.

The respondent refers to the environment and how some changes could help to boost the woman psychology during her stay in the hospital. However, he believes that a change in the staff's attitude could help to make the atmosphere more pleasant for the woman. She will feel relaxed and more comfortable to speak up and express her queries. The way proposed is for the staff to receive psychology lessons and try to be pleasant and understanding with the women.

The suggestions proposed by both the midwives and the doctors mainly lie on the relationship formulated with the woman and the effectiveness of communication. In addition they all made comments on the current environment and how some small changes could benefit the woman. An analytical discussion of the findings within the framework of the current literature is presented in the following chapter.

8 DISCUSSION

The main issues that arose from the findings fall into four main areas and this is presented in the framework discussed below.

8.1 Dissemination of information

Although the prevalence rates of postnatal depression is well demonstrated worldwide the lack of adequate information over it has been reported from both midwives and obstetricians (Abou-Saleh et al 1997, Cooper et al 1999, Beck 2001, Yamashita et al 2000, Lee et al 2001, Danaci et al 2002, Patel et al 2002). Both groups referred to their educational curriculums and the limitations existed not only over postnatal depression itself but in mental health generally and psychological approaches. Seminars or other interdepartmental lectures include topics more common to the everyday practice such as postpartum hemorrhage or fetal monitoring. This probably demonstrates the importance given to the woman's physical health over every other aspect of her well-being. Another reason might be that postnatal depression is not a common phenomenon for the particular health care providers and therefore it lacks attention.

The failure of the health care professionals to detect postnatal depression might be due to the inadequate information and knowledge provided during training (Eden

1989, Mauthner 1997, Tong and Chamberlain 1999, Stewart and Henshaw 2002, Keng 2005 and Skocir et al 2006). Skocir et al (2006) demonstrated that most of the midwives were not fully aware neither of the signs and symptoms or the onset of postnatal depression. There was confusion amongst its characteristics with most midwives mixing it with maternity blues and puerperal psychosis. Exactly the same result was found from both Eden (1989) and Keng (2005). Most midwives in the studies mentioned felt unable to distinguish the differences between the mental health disorders in pregnancy and puerperium. Similar findings were extracted from the present study as well.

Only two midwives reported personal experience of a mental health incident which happened almost immediately following delivery. Midwives in this study referred to symptoms such as hallucinations, confusion and suicidal thoughts. According to the literature the symptoms described and their onset are closer to puerperal psychosis than postnatal depression (Cox 1986). Limited experience of postnatal depression might be due to the lack of contact with women after they leave the hospital. Midwives in Greece do not deliver home visits routinely either the antenatal or the postnatal period. They see the woman only during her hospital stay and the information known about them is limited. Therefore, the confusion amongst signs and symptoms could be justified.

Obstetricians on the other hand seemed more aware of the symptoms and onset of postnatal depression. They all described incidents happened after women left the

postnatal ward and the symptoms given are closer to postnatal depression according to the literature (Cox 1986). However, none of the obstetricians felt comfortable to detect or to treat postnatal depression and them all identified gaps in their education over the particular matter. Three studies by the CARN were conducted between 2001 and 2004 to look at obstetrician's knowledge and attitude towards major depressive disorders (Coleman 2004). Two of them looked at depressive episodes over many periods of a woman's life such as adolescence, postpartum and premenopausal (Coleman 2004). Both of them concluded that obstetricians were not paying enough attention to the DSM-IV criteria and that could attribute to the underdiagnosis of depression (Coleman et al 2004).

The third one looked at the obstetricians and gynecologists' personal experience with depression and how that could influence rates of screening for depression and treatment (Coleman 2 et al 004). Results suggested that clinicians who had a recent experience of a close person suffering of depression were more reluctant to screen for it (Coleman et al 2004). The reason being is that a personal experience could have made them more sympathetic and they were inclined to recognize the signs and make the appropriate referral. It is the same result found in this study where one of the obstetricians reported that younger doctors might be in a position to understand women because they probably had a personal experience themselves and they were more aware of the changes happening to women during this period.

A similar study was carried out by Dietrich et al (2003) with the assumption that newly qualified obstetricians and gynecologists were more confident in diagnosing and treating postnatal depression. It is acknowledged that fewer than half of the respondents felt prepared from their training in the hospital to recognize or treat depression (Dietrich et al 2003). However, it suggests that both groups included in the study of experienced and newly qualified obstetricians were overall confident to recognize signs of depression but less confident regarding its management (Dietrich et al 2003). The findings of the study imply that newly qualified obstetricians were more confident with the concept of depression because they had more extensive education in their curriculum. In addition they were more inclined to raise awareness and cooperate with the mental health teams rather than trying to manage it themselves (Dietrich et al 2003).

Unfortunately the results of the current study are contradictory to the results from the study above. Neither experienced nor young obstetricians felt that they had adequate education over mental health issues especially on their management. However, they mentioned that with experience in practice they might be in a position to detect signs but still they are not confident to offer active management.

8.2 Environment of care provision

The lack of time and staff shortage was two dimensions of the current health care setting that both the midwives and obstetricians referred to. Both groups in the study

mentioned that there is not enough time to spend with the woman. Heavy workload was mentioned by the respondents with the midwives referring extensively to the fact that there is a major staff shortage. Midwives feel that when they were alone with a vast number of women to look after they could not do anything else but to perform tasks and ensure that the basic aspects of care are covered. It is the same with the obstetricians where they were not able to dedicate sufficient time to every consultation and thus the focus is on clinical aspects of pregnancy alone. Speaking about time constrains the midwives focused more on the provision of postnatal care where the obstetricians mostly on the antenatal care. The reason for that might be the structure of the current system where the antenatal care is provided from the obstetricians and the postnatal one during the hospital stay by the midwives. It is worth mentioning here that many studies have been done in order to explore the women's perspective over hospital based postnatal care but only few to explore the midwives' views (Cattrel et al, 2005, Dykes 2005, Rayner et al 2008).

The results from the current study are similar to Rayner's et al (2008) research project. Rayner et al (2008) attempted to illustrate the views and experiences of midwives provided hospital-based postnatal care. Organizational issues arose from half of the number of the midwives interviewed with staff shortage being the first one. The midwives felt that the ratio amongst the midwives and the women was low in order to allow time for individual care. Certain routine practices such as postpartum observations were occupying most of their time and the care became more task oriented (Rayner et al 2008). This was a barrier to the midwives'

perception of empowering women with continuous advice, support and communication (Rayner et al 2008).

Cattrel et al (2005) in their study reported that midwives most of the times were not able to provide adequate postnatal care. Midwives felt that they wanted to provide more towards the physical and the emotional well being of women. However, lack of time and a great amount of administrative work and routine care were two very important factors prohibit it to happen (Cattrel et al 2005). Similarly, Dykes (2005) identified that organisational and resource pressure were an obstacle for midwives to provide sufficient care. The midwives also felt the hospital postnatal care was underestimated in comparison to the antenatal care and labour ward. They did not have the time to bond with the mothers and meet their breastfeeding needs (Dykes 2005). The current study complies with the results from the above studies as midwives reported that the main focus of care was the delivery and after women gave birth less attention was paid. This might be because a safe delivery and the health of the mother and the baby are of primary importance. Thus the focus is more on the physical care than the mental health well being of women.

Another finding that is in line as well with the findings of the current study was the friendly consistent advice midwives wanted to provide women with (Rayner et al 2008). In the current study two thirds of midwives reported that they would like to provide women with updated information and have the time to discuss with them thoroughly all the aspects concern them. Midwives believe that this would increase

women's satisfaction and might reduce their stress levels. In addition it could give them the time to approach the women and make them feel comfortable to ask any query they might have. It could be assumed that this approach would make women more confident about the baby's care and their health as well. Those findings are in line with other studies mentioned in the literature where they examined women's satisfaction from the care they received on the postnatal ward during their stay in the hospital (Garcia et al 1998, Beake et al 2005, Rudman et al 2008, Yelland et al 2009). Women in those studies reported that they valued professional advice and they would like to be informed regarding every issue surrounding their health and the baby's care (Rudman et al 2008, Yelland et al 2009). Midwives in this study believe that due to the lack of time and staff shortage they feel that they might neglect women and their needs might go unmet. Nevertheless, if not enough attention is paid to women's postnatal needs certain signs and symptoms which could lead to postnatal depression might go undetected and no necessary action will be taken.

In addition midwives reported that the unlimited visiting times were a constant interruption to the women's rest following delivery (Rayner et al 2008). This is in line with the current study as midwives reported that the woman cannot stay alone to rest and bond with the baby. Women's mothers (grandmothers) are the ones who even stay overnight and constantly looking after the baby. The family in Greece is the main support system and therefore the grandmothers feel responsible that they have to be constantly present (Gonidakis et al 2008). The midwives comment that in this way women might have constant support but on the other hand they do not have the chance to learn how to look after their babies themselves. In addition, the

midwives felt that the women were getting conflicting advice. The grandmothers were applying their empirical knowledge and they were not accepting any new information regarding baby care. Unfortunately there is not enough evidence in the literature for the particular area. Therefore, further research is required probably from countries with a similar culture.

The concept of home visits is well established in the literature and their benefits for women in both their physical and psychological well being (Kitzman et al 1997, Morell et al 2000, MacArthur et al 2002, Quinlivan et al 2003).

A new model of community postnatal care was aimed to be developed and implemented to practice (MacArthur et al 2002). The model would be based on maternity care recommendations following research (MacArthur et al 2002). Another aim of the project was to compare the effects of such care on women health compared to the ones who did not have it (MacArthur et al 2002). Women, midwives and General Practitioners were involved in a cluster randomized control trial (MacArthur et al 2002). A control group of women was used in comparison with the group under study. The results of the new model of care applied showed an improvement on the women psychological health four months postpartum. The EPDS was used to assess women's psychological well being and there were positive outcomes. The early detection and management of mental health issues could explain the improvement on the women's psychological health. Ray et al (2000) and Clement et al (1999) support this outcome. It argued, however, that this model could not only

be used for women at risk of depression but at any level of mental well being (MacArthur et al 2002).

Home visits are not a common practice under the Greek health care system. Midwives are not involved in the postnatal care after women leave the hospital. Women as it was mentioned before are staying in the hospital for three days following a normal delivery and five days after a caesarian section. After that they do not meet either with an obstetrician or with a midwife routinely until the six weeks postnatal check. If any problem arises during that period they are going to visit the obstetrician. The reason for lack of home visits might be the shortage of midwives to perform the certain task. Thus the current health policy suggests this length of stay in the hospital so further risks to the woman's health are minimized. The length of their stay in the hospital might ensure that any complications such as postpartum hemorrhage or retained products will be resolved and no risks involved when the woman goes home. This could leave the women with no professional support and that might increase the chances of women who develop postnatal depression to go undiagnosed.

8.3 Perceptions of health professionals on their clinical role and the provision of PND care

The role of midwives to the provision of maternity care is well established in the literature (Page 2003, Hunter 2004, Hunter et al 2008, Larsson et al 2007).

According to the International Confederation of Midwives (2005) the midwife is a 'responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period....This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care'.

Midwives in Greece receive adequate education which prepares them to become autonomous practitioners for normality (TEI Athens 2009). However, in Greece there is no established midwifery model of care and the vast majority of deliveries are performed in hospital confinements mainly by obstetricians. It is possible that the increased use of the technology and the shift from home births to hospital births aimed to achieve maximum safety through medical assistance and it has played a very important role to the medicalisation of birth (Odlind et al 2003). The midwives in the current study feel that their role was underestimated and they had almost no involvement with the woman's care during pregnancy. That made them feel that they were only task oriented and they had no chance to offer anything else.

Hunter (2004) identified similar findings where hospital midwives in her ethnographic study felt that they were under pressure to perform and complete tasks driven by the hospital guidelines. It is the same with Ball et al (2002) where the UK midwifery staff morale was low and that led many midwives to leave their job. However, the difference in this study is that midwives were feeling underestimated and

unrecognized because they did not have the chance to practice one hundred percent what they were trained to do so. It is demoralising to them the fact that they cannot perform autonomous care during pregnancy or to conduct normal deliveries on a routine basis. The midwives view themselves as 'the confess man' and that women could feel very comfortable with them and reveal intimate personal information with the view of help. Schmied et al (2008) in their study attempted to identify strategies to improve hospital based care. The midwives in their study during the interviews spoke about meeting the needs of a woman both emotional and practical as well as having a trusting relationship with her (Schmied et al 2008). In addition midwives felt that they were mainly performing tasks and they were bound by the obstetricians in many of their decisions. The findings are concurrence with the findings of this study as midwives reported that they were under the shadow of the medical profession and they could not act independently at any stage of pregnancy, delivery or postpartum. The current system in Greece does not allow immediate comparison with other kinds of midwifery practice such as community midwives

Although most of the midwives attention was focused on postnatal care, their perceptions did not differ regarding antenatal care and care during labour. They claimed that they felt the care was overtaken by the obstetricians and therefore they could not provide adequate care.

A focal point from the midwives perceptions is that the medicalised system surrounding childbirth was supported from the women themselves. Obstetricians

were viewed as the experts and women probably because they were anxious regarding their health and the baby were totally relying on them. The system regarding childbirth has been medically oriented for several decades and it might be difficult to change people's perceptions. In addition the public perception is reinforced by the current system where it prioritises medical responsibility for maternity care (Brodie 2002, Jardri et al 2006). These are viewed as barriers from the midwives who aim to increase the women's ability to access midwives particularly during the antenatal and the postnatal period. Such an attempt has started recently in Greece from two mothers who are trying to form an association to promote normality and increase women's choices regarding birth. This might be a beginning for women to get informed about different models of maternity care and endorse a different perspective than the medical model alone (Sapountzi-Krepia 2009).

The obstetricians saw themselves as clinical providers and most of them make a clear distinction regarding their role. First priority to them is the health of the woman and a safe delivery for the baby (Pottinger et al 2009). However, there were some of the obstetricians who considered their role more complex and they would like to be able to offer holistic care to the woman and not focus on the physical health. Especially younger obstetricians feel that they are in a primary position to help women because they had recent experiences themselves and they could understand better the women's needs. It is evident by Coleman et al (2004) that personal experience might make younger obstetricians to be more sympathetic and pay more attention to the woman's psychological status.

On the other hand, two thirds of the obstetricians mentioned that women distinguish the roles of different professions. It is argued that most of the times it is women themselves who ask for the care to be focused on clinical aspects alone. Women might feel that the most important thing at the particular time is the baby and everything else is of secondary importance. The science based medical model of care might have become so influential on society that women might unconsciously think in this way (Freeman et al 2006). However, it might not only be the women's attitude but the obstetrician's approach towards postnatal depression.

The total number of obstetricians in this study stated that they do not pay attention to the women's psychological status. This contrasts the guidelines that are already in place with regards to screening for postnatal depression during pregnancy in systems similar to Greece like the United States (Flynn et al, 2009). Theoretical literature though suggests that screening during pregnancy is essential in order to detect women at risk (Kelly et al 2001, Wisner et al 2006, Pottinger et al 2009, Gonidakis et al 2008, Flynn et al 2009). The perception of the role distinction is the central focus of the obstetricians. However, it could be argued that because screening for postnatal depression is a routine practice neither in pregnancy nor postnatally in Greece, obstetricians are not familiar with it. It is highly likely that if screening was a routine practice health care providers would be obliged to turn their focus in that aspect of health as well.

Midwives and obstetricians argued that women share some fault in that mentality. It was very difficult for women to share sensitive information with the health professionals because they thought that no confidentiality was kept or they might be

stigmatized (Flynn et al 2009). The population of the city might have been an issue as it is not as big as Athens [capital of Greece].

Stigma was a major issue reported from both midwives and obstetricians. Both groups reported that women were aware of cultural stereotypes and they were possibly afraid of rejection. Women might have thought themselves as failures and this could have led to low self-esteem and self-efficacy (Corrigan et al 2005). The particular issue has been explored in several studies and they enhanced the importance this has to the new mothers (Whitton et al 1996, Edwards et al 2005). Whitton et al (1996) examined the women's perception regarding postnatal depression and how that could affect their decision to accept treatment or not. The study identified that fear of stigmatisation could lead women to go untreated (Whitton et al 1996). A qualitative study performed by Edwards et al (2005) identified that feelings of being a bad mother, disclosure and access to services were the key issues for women suffered with postnatal depression. According to Edwards et al (2005) women felt that health professionals were lacking of understanding towards this type of mental illness. Our findings are in line with the studies performed, although a direct comparison cannot be done as those refer the women's perceptions directly. Health professional explained that the local mentality could be very judgmental over mental health. There were incidents reported from obstetricians in this study that women did not reveal that they were under psychiatric follow up. Women might have thought that motherhood should be a joyful experience and that if health professionals new about their status that could have changed their attitude towards them and consequently their care.

Despite all that midwives were extensively referred to the role of the family and the support system women have if any situation arises. The family in Greece plays a very important role and it is the main support system as in other traditional cultures such as Turkey and Arab countries (Stuchbery et al 1998, Inandi et al 2002). The women were protected within their family and they did not wish any personal information to be revealed outside this circle. The family with possibly the fear of the stigma overprotected the woman and was trying to keep her safe. Any problem arose the family was trying to deal with it without giving the chance to people outside it to find out or to make any comments about it. Lack of social support has been identified as a major risk factor of postnatal depression. However, Inandi et al (2002) study revealed that forty percent of the women who developed postnatal depression had a very strong and traditional family support system. It might be to the woman's disadvantage if she keeps her worries within the family and no professional support asked. Undiagnosed and untreated postnatal depression might occur as severe outcomes of this particular mentality.

8.4 Synthesis

The issue of forming interpersonal relationships and therefore trust amongst the health professionals and the women was the major topic arose in the study. Continuity of care was the means to achieve them according to the study respondents. All the respondents felt that this was the way forward if they wanted to contribute in the identifications of risk factors and offer appropriate referral. Pottinger et al (2009) conducted a study in a country with a similar maternity system

and one of their objectives was to raise the concerns of women in a hospital-based obstetric clinic regarding postnatal depression. It was a prospective longitudinal study with 452 women taking part. Women reported that they needed to be encouraged to talk to their doctor regarding any psychological issue (Pottinger et al 2009). Discussions could be facilitated in the obstetric clinic and the women would benefit if they could relate to their health care providers.

Saultz et al (2004, p:445) defines interpersonal continuity with the clinicians as ‘a special type of longitudinal continuity in which an ongoing personal relationship between the patient and clinician is characterised by personal trust and responsibility’. Green et al (2000) mentioned that continuous care appears to establish a trusting relationship. Their study provides evidence that continuity of care delivered via a caseload model, could achieve meaningful relationships based on trust (Green et al 2000). Mothers of their study felt that they were able to communicate their needs more effectively and they were in a position to trust their health providers (Green et al 2000). Williams et al (2009) stated similar findings as the continuity of care was highly valued by the women as a means to develop a trusting and supportive relationship with the midwives. Both the groups in this study argue that only by having a trusting relationship women could open up and reveal their needs, their fears and their expectations. This could lead the health professionals to identify women at risk of developing postnatal depression and provide them with the appropriate support.

A suggestion that came mainly from the obstetricians was a multidisciplinary team of care and in particular the incorporation with the mental health services. It is argued that it would be beneficial to women if they could have the chance to speak to a psychologist during the pregnancy and postpartum and discuss with them any other matter than obstetric ones. Specialists could be in a privileged position to elicit information regarding women's psychological status and offer the appropriate support. Flynn et al (2009) supported their views and they proposed onsite mental health services that women could be directed at any time. The present study suggests that multidisciplinary care schemes could possibly help women by satisfying all their needs at any level. In summary, there were four main areas identified. These areas relate to the clinical practice of maternity care and they are illustrated in the figure below.

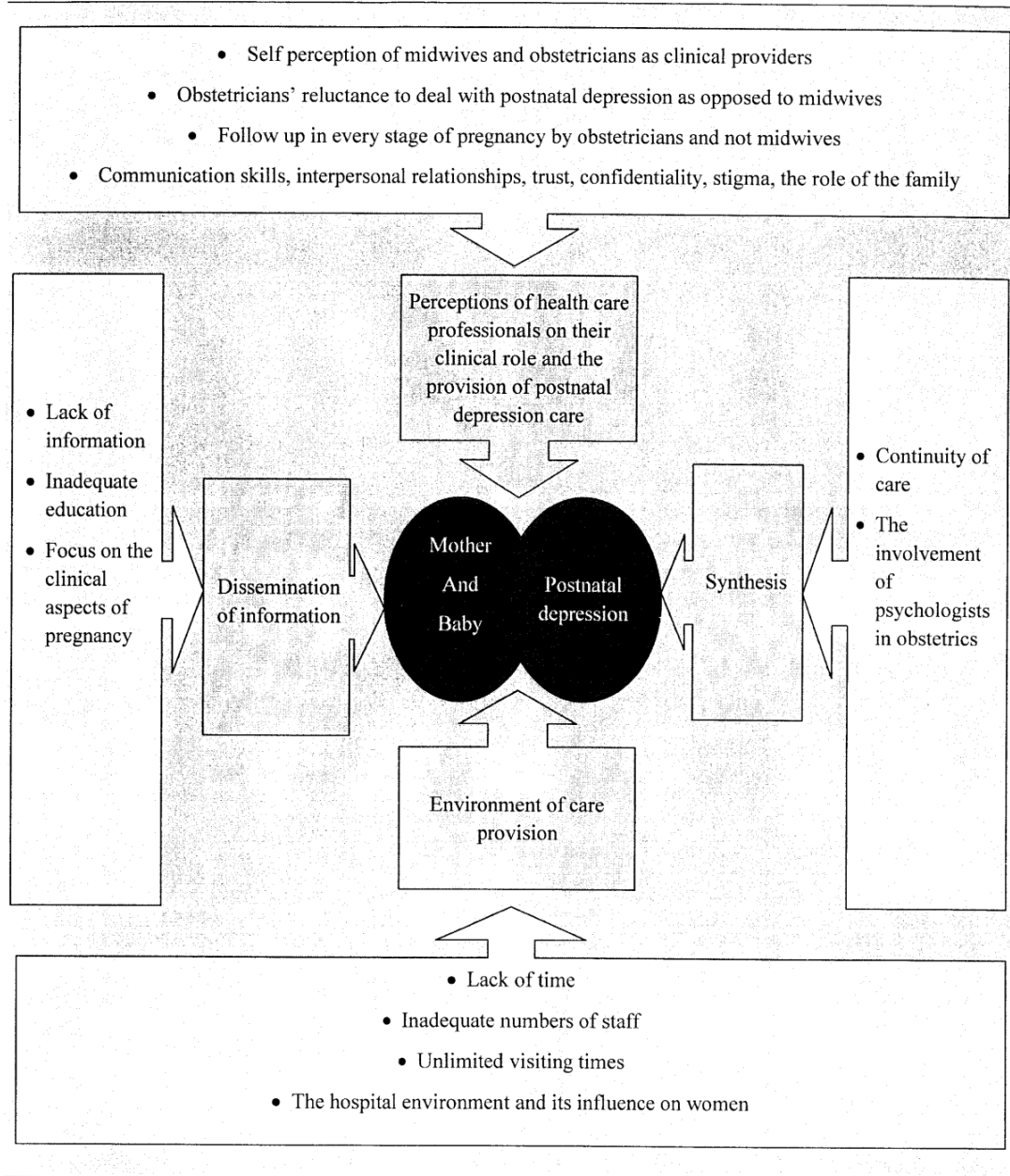


Figure 1: The framework that derived from this study

A framework of care that incorporates midwives, obstetricians and mental health professionals which aims to individualised care might be beneficial to the provision of maternity care. The framework derived from this study could be linked with the theory constructs the division of labour (Allen et al 2005). Both midwives and obstetricians are autonomous practitioners and although they are serving different scopes of practice, they both aim to the provision of adequate care in relation to childbearing women. However, several factors identified in the study that might affect the dynamic relations between the health care professionals and as pointed by Allen (2001) in this context the division of labour could be conceptualised as a social system influenced from external and internal forces that might have an effect on the occupational boundaries.

Postnatal depression might seem a complex issue to women and it could affect their views of themselves as mothers. Therefore, it is important for the health professionals to normalise it and non-stigmatise it by giving the correct information through effective communication. A continuous encouragement and an emphasis to the positive effects of motherhood should be given and all these could determine if women would be more reluctant to open up and speak about every issue might affect their health.

8.5 Summary

The main findings of the data analysis were discussed in this chapter in connection to the literature. Dissemination of information, the working environment, the role of the health professionals and their perceptions towards postnatal depression as well as their suggestions were presented as the framework derived from the findings of this study. The researcher attempted to have an overall critique and a graphic representation of the framework emerged from the study.

9 CONCLUSIONS

The final chapter six in the thesis will reflect on the research process and will offer recommendations for future research studies in maternity care. Chapter six will

1 Offer final reflections on the analysis of this ethnographic study

2 Make future recommendations for research in maternity care and curriculum education and clinical practice itself

3 Discuss the limitations of the research study

9.1 Final reflections on the analysis of this ethnographic study

The process of data analysis in this study was embodied in every stage of the research process and has not begun once the data collection was complete. As the study progressed it was important to find a way to manage the large amount of data collected and in a sense that was part of the analytical process. It was viewed as an essential task to have a richer understanding of the data as a whole and not only in separate pieces as they were developing.

It seemed a big challenge for the researcher to find her way around the qualitative methods in both the social sciences and the nursing literature. The concept of postnatal depression was largely unexplored in Greek literature and there were no precise directions how this research might be conducted within the context of maternity care. However, the allocation of adequate supervision allowed the

researcher to review and organise the research process. A pilot study was highly recommended in order to test both interviews and observations and enhance the rigour of the research process.

Within the ethnographic concept of the study, the data analysis became more focused as the research proceeded rather than the initial broad phase. An inductive approach was used to frame the data analysis process which was guided by the existing qualitative literature. This has helped the researcher a lot to organise the data and start making sense of it. The thirteen steps of analysis by Burnard (1991) were used as a specific method of analysing the data. From the analytical process categories and themes emerged and they were used in order to clarify and describe the main domains of the maternity care in Greece. The researcher had the opportunity to discuss her work with her supervisors in every stage of the analytical process and valued their constant support in terms of references and discussion. Nevertheless, the researcher became more focused in the data analysis process through personal involvement and constant reflexivity.

The findings from this ethnographic study took the researcher by surprise and this might be due to the fact that the researcher has been abroad and working in a different system for quite a few years prior and during the data analysis. In addition, the research felt that the study overall has affected her as a person, as a midwife and as a researcher.

As a midwife, this study gave the researcher the opportunity to have an insight of the maternity services in Greece and how the concept of postnatal depression was viewed by the health care providers. Their perception of postnatal depression and the care provided made the researcher to look back on her own practice as a midwife and realise how task oriented her practice was. This study enabled the researcher to see things from a different perspective and question practices that she has never thought about before.

As a researcher this study allowed the development of her research skills and gave her the chance of critically thinking and questioning different issues rather than take them for granted. It has also helped the researcher to become more independent through the study process and that evolved throughout it. The knowledge generated from the study has empowered her as a midwife and as a researcher.

This ethnographic study allowed the researcher to create a framework that illustrates the current situation of the maternity services in Greece. The concept of postnatal depression has been seen within these services and explored their effect on the particular subject. The mentality of the local society towards maternity and mental health has been depicted through the views of the health care providers and its effect on the care provided regarding postnatal depression.

The researcher considers that this study has helped to elucidate an area previously unexplored. It has taken a realistic view of this issue, and enlightened the

understanding of the processes underlying the service delivery. It has demonstrated that it is constructive to incorporate a framework that provides a holistic view towards women's care and provide valuable information to support high quality service delivery. Therefore, it is proposed that the current research has fulfilled the objectives posed at the beginning and has advanced the theoretical and practice understanding of the study phenomenon.

9.2 Recommendations

This research study has offered new information related to maternity services in Greece. It illustrates the current services provided and the perception of the care providers themselves. The findings of this study suggest that future research should be more focused on the service users' views particularly in Greece where the research in that area is limited. The findings of this study highlight many areas that further exploration is required.

- The study concluded that there is a need to address women's perception of the maternity services provided in Greece and offer their recommendations.
- Women who suffered from postnatal depression could share their experiences with a view to be implemented in the current practice.

- The current study demonstrated the necessity for management plans which could give the opportunity to women to express their needs either physical or emotional.
- The study has shown that there is a need to promote education in both midwifery and medical curriculum regarding mental health issues in pregnancy and they should be reinforced in undergraduate and postgraduate education.
- Further practical training for the staff within the maternity services is required to be in a position to approach the subject and take the appropriate action.
- Multidisciplinary team work is one of the suggestions arose from the study itself. Involvement of all the disciplines needed is essential in order to achieve holistic care for women.
- This study should be disseminated to policy makers who plan maternity services. It might help to address the issue of postnatal depression in future policies and guidelines so mental health becomes part of the care provided.

9.3 Limitations of the study

The fact that it was a single researcher working on a part time basis over a set period of time proposes a limitation for the study. This research was not indented to provide a summary of all what is known about postnatal depression; rather it was an attempt to develop an ethnographic study and to illustrate from the midwives and doctor's views the current situation in Greece. Therefore, it could not in a sense be final as any field of inquiry as clinical practice is constantly changing.

9.4 Future research questions

Questions that could be raised in future research studies are:

- What is the role of the family in Greece and how it affects current maternity polices?
- What support systems are in place to deal with mental health issues surrounding pregnancy?
- Is there clarity towards women's opinions regarding maternity?
- What is the perception of motherhood in Greece?

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APPENDICES

Appendix 1: Semi-structured interview schedule

1. How long have you been a midwife/obstetrician?
2. Why have you decided to become a midwife/obstetrician?
3. Have you ever faced a case of postnatal depression
4. What kind of information have you got about postnatal depression and where from?
5. To what extent do you think midwives/obstetricians might be in a position to identify risk factors leading to postnatal depression?
6. What is your opinion regarding how family and/or society would face a woman with postnatal depression?
7. What do you believe is the role of midwife/obstetrician as care providers towards postnatal depression?
8. According to your opinion, what might affect the provision of care in relation to postnatal depression?
9. How do you think the particular working environment could affect the care provided?
10. How do you think the particular environment would affect women?
11. What would you suggest for the improvement of the care provided regarding postnatal depression?
12. Is there anything else you wish to add before the end of the interview?

Appendix 2: Interview Example: Midwife

R: How long have you been a midwife?

M: 13 years roughly.

R: Why have you decided to become a midwife?

M: It was a rather fortuitous choice. However, during the working years I realised that this work suits me. That is what I want to believe.

R: What you mean it was rather fortuitous?

M: The system that prevails here in Greece with the University entry exams. You fill a certain form and then it depends on your grades you have the choice.

R: And during the years you said you said that it suits you?

M: I believe that it suits me as a profession, I like it. Because you are in contact with young people, with the future mothers, the infants. You feel satisfaction even in a very difficult labour when you have a very good result. That is to say, a healthy mother and a healthy infant.

R: Have you ever come across any cases of postnatal depression

M: Look, because I work on the delivery suite, the time where I am in contact with the women is limited. That is to say, what the duration of the labour is going to be, depending on what para the woman is, and two or three hours after labour that she remains in the labour unit for follow-up. Therefore, I believe that it should be so much of a serious problem for the woman to manifest something at that moment.

Because, me personally, I almost have no contact with the women. Only socially, if I

meet them at some point in the maternity unit or somewhere outside after a long time. But, for the vast interval of time unfortunately I have no contact with the women.

R: What kind of information have you got about postnatal depression and where from?

M: Not particularly much of information. And me personally what I have heard is either in some conferences which I have been or from colleagues' studies, scattered things, or from certain magazines. Possibly I was not concerned I have not searched.

R: Why do you think there is scrappy information?

M: I believe that first of it is our own negligence. If somebody wants to learn something he will find the way. Because nowadays with the technology and via Internet, via so many studies, I believe that we could be better informed. But, maybe is the pressure of work, maybe the tremendous lack of staff that exists in our clinic. If I tell you that for a two months period we were four people working on a rotation basis because we had some people on sick leave, some on maternity leave, so that we were working for 10 days without a day-off. Therefore, information for various subjects not only the particular one, comes in a second degree.

R: what is your opinion about the care provided?

M: What should I say. I cannot have an opinion because here the obstetrician exclusively does the follow-up of the pregnant woman that is to say, midwives do not deal with it that much. Apart from the 4-5 midwives that work in the antenatal clinic which will see certain women, the rest of the staff either the pathology of gestation or

the labour unit or the maternity unit will suddenly see the woman. The bell will strike after a conversation over the phone and here she comes, a primipara or multipara with so much cervix dilation. From there on one of the midwives on duty will deal with the woman from the moment she arrives in the labour unit and afterwards. She can have such cervix dilation that she can give birth within half an hour, two or three. We don't know anything about the woman prior to this. I am telling you that this is because the doctor has the follow up during pregnancy exclusively. Now, how much obstetricians themselves can realise certain things, how much time they allocate for the each woman, that I believe that they allocate limited time, so that they can deal with her mental health as well. Unless there is something pre-existing and is also known by the woman herself. Don't forget that the societies here in Greece are very closed and there are certain things that even women themselves who are aware of are ashamed to talk about. In order not for the husband to find out, or the mother – in law or somebody from the hospital staff that happens is to be known, relative, fellowvillager.

So that we have seen, but seldom and such incidents, that is to say problems of mental health that the woman herself would deny for these reasons.

R: When a woman comes in the labour unit and you take care of her, where is this care focused and why?

M: The care is focused basically in the follow-up of the foetus. The woman will be connected to the non-stress test in order to watch the vibrations and the twitches of uterus. A vein flow will be placed just in case medication needed. I believe that the woman herself comes in second fate. And many times we behave depending on how the woman herself will be. If there is a friendly woman, we will also be friendlier. If

there is an aggressive woman, without of course examining what could pre-exist...A woman might be aggressive because she is afraid, especially if she is a primipara and is absolutely reasonable that she is afraid. Because, something might have happened in the familial environment. Because no one explained to her the process of childbirth in simple terms. We behave depending on whether the woman will ask something, (hesitation) depending on her own behaviour.

R: To what extent do you think midwives might be in a position to identify risk factors that could lead to postnatal depression?

M: I believe that if we were dealing more with the women and specifically with the follow-up of gestation, we could realise quite earlier than the obstetrician does or somebody from the intimate familial environment of woman. Because I believe that a woman, expresses herself much easier in a midwife. Whereas in the midwifery profession the highest percentage are also women. Yes she will go to the obstetrician because she feels scientifically confidence, but because most of the obstetricians are usually men, I don't believe that a woman will open up easily. And I believe that the doctor will deal exclusively with the baby's good health, via the ultrasounds and the follow-up of gestation. If there are further problems, or other concerns, she won't say easily. I imagine that if midwives were dealing more with the follow-up of the pregnant woman, they could realise certain things much earlier,

R: What is your opinion regarding how family and or society would face a woman with postnatal depression?

M: I think with difficulty here in Greece, because I believe that they do not admit it easily or they do not want the problem. I believe that it will be difficult them to help

this woman, because it is related with the educational level, the leaving standards and the relation of the couple itself. What kind of relationship they have developed or how desirable this pregnancy was, this child, if they made a right family planning so that they can face such a situation if it results.

R: What do you believe is the role of midwife as care providers?

M: With the current situation I believe that it is non-existent. That she cannot do many things. Perhaps if we were functioning in a different way under the significance that we made a team. Some of the midwives where we are in contact with the woman, during the postnatal period, we were doing home visits, twice or three times postpartum, I believe that our role would be much better, much more efficient in order to understand certain things. Now I think that we cannot do many things, because as I explained to you before, the follow-up is from the doctor. We see the woman suddenly, like one unit, a certain woman that comes to give birth, a name.

R: According to your opinion, what might affect the provision of care in relation to postnatal depression?

M: Perhaps and some other motive could be if we had some bonus work wise. What we say a day-off, if somebody was dealing more, if she/he was doing home visits. Because from our side only I do not think it would be such an enthusiasm, because as I said to you before, there is a great lack of staff.

R: How do you think the particular working environment would affect the care provided?

M: I believe that we do not do what we supposed to. Because when you are two -

three individuals on duty and it happens to have six - seven, women on labour your priority is to deal with the woman in labour and not with the postpartum one. And the postpartum one we see her many times, as 'a she is a woman that has given birth, the mother is well, the baby is well, hence finished'.

R: When you say you deal with the woman in labour, what you mean?

M: Substantially with the follow-up of the non-stress test [ECTG]. If the woman has regular contractions. If there is a need for certain medication. That is to say we focus more our interest there and we put the postpartum woman in second fate.

R: How further more you take care?

M: We deal as long as the pressure of work allows us, with not only to seat opposite an instrument, a non-stress test and watch, but have some discussion with the mother. Many times she expresses certain queries where we are called to answer and the most frequent are 'if things are going well up to now', 'in how long is she going to give birth', 'how are her contractions'. Many times we try to shift the discussion to make her forget. Because unfortunately here in our labour unit they are very few women who have somebody from their own environment with them. It is not allowed as in certain other hospitals. It should be the person that the woman herself wishes to. Because somebody may wish her mother, somebody may wish the husband, a friend, or her sister. Unfortunately here the woman is alone in the labour unit. Many times she feels like a stranger in the labour unit. She comes in and sees a person that has never seen before. I imagine that if during labour the person that she wishes to was with her, possibly such problems of postnatal depression were not presented later or this person who was with her might have realised things earlier, had some

indications. Here the husband is allowed provided that he has followed the antenatal classes and has taken a card. But don't imagine something so exciting. The husband is allowed to visit the maternity clinic twice and attend some theoretical courses. And from what I have seen most of them they don't help not even in terms of moral support. That is to say 'everything is fine', 'be patient, we won't be late, we will have our baby in a while'. Most of them during the labour time turn white and they do not enter. They do not want they see blood, the baby the time when it comes out with amniotic fluid, with the blood. However, I believe that if someone and I repeat the one that the woman herself wants to, was present, maybe women would react better, behave better.

R: What do you would propose for the improvement of care regarding depression.

M: I believe that also the courses of painless childbirth that include certain exercises, certain breathings would be supposed to begin very earlier but also to become also certain courses of maternal art. From the way that will touch the mother the newborn, from how him it will change, from how will appreciate certain changes above in the newborn.

R: You would like to add something else

M: I would like to add [pause] I said it many times, if the pregnancy follow-up comes from us [pause]. The doctor should be in the scientific part but with regards to the contact with the woman and certain courses of maternal art I believe that this is clearly our role.

Appendix 3: Burnard's 13 steps of Analysis (Original Paper)

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A method of analysing interview transcripts in qualitative research

Philip Burnard

A method of analysing qualitative interview data is outlined as a stage-by-stage process. Some of the problems associated with the method are identified. The researcher in the field of qualitative work is urged to be systematic and open to the difficulties of the task of understanding other people's perceptions.

INTRODUCTION

Qualitative research methods are being used increasingly to explore aspects of nurse education. Often, such methods involve the use of unstructured or semi-structured interviews as a principle methodology. Sometimes, the interview process is straightforward enough (though, as we shall see, this is by no means always the case). The difficulty often lies with the question of how to analyse the transcripts once the interviews have been completed. As in all research, it is essential to know what sort of method of analysis you are going to use before you collect data. This paper offers one method of analysis.

It should be noted that it is one method; essentially, it is one that can be described as a method of thematic content analysis. It has been adapted from Glaser and Strauss' 'grounded theory' approach and from various works on content analysis (Babbie 1979; Berg 1989; Fox 1982; Glaser & Strauss 1967).

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Assumptions about the data

No one method of analysis can be used for all types of interview data. The method described here assumes that semi-structured, open-ended interviews have been carried out and that those interviews have been recorded in full. It is also assumed that the whole of each recording has been transcribed. It is suggested that an adapted version of this method could also be used for data arising from more clearly structured interviews.

The method used to categorise and codify the interview transcripts is best described though the stages that are worked through by the researcher. The method was developed out of those described in the grounded theory literature (Glaser & Strauss 1967; Strauss 1986) and in the literature on content analysis (Babbie 1979; Couchman & Dawson 1990; Fox 1982) and out of other sources concerned with the analysis of qualitative data (Bryman 1988; Field & Morse 1985).

AIM OF THE ANALYSIS

The aim is to produce a detailed and systematic

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recording of the themes and issues addressed in the interviews and to link the themes and interviews together under a reasonably exhaustive category system. Herein lies the first problem that the researcher must remain aware of. To what degree is it reasonable and accurate to compare the utterances of one person with those of another? Are 'common themes' in interviews really 'common'? Can we assume that one person's world view can be linked with another person's? The method described here takes it for granted that this is a reasonable thing to do. However, the researcher should stay open to the complications involved in the process and not feel that the method described here can be used in a 'doing by numbers' sort of way.

- A major category seems to be emerging to do with 'coping with anger in counselling'.

Stage three

Transcripts are read through again and as many headings as necessary are written down to describe all aspects of the content, excluding 'dross'. Field and Morse (1985) use the term dross to denote the unusable 'fillers' in an interview – issues that are unrelated to the topic in hand. The 'headings' or 'category system' should account for almost all of the interview data. This stage is known as 'open coding' (Berg 1989); categories are freely generated at this stage. An example of this sort of coding is found in Table 1.

STAGES OF THE ANALYSIS

Stage one

Notes are made after each interview regarding the topics talked about in that interview. At times throughout the research project, the researcher also writes 'memos' (Field & Morse 1985) about ways of categorising the data. These serve as memory joggers and to record ideas and theories that the researcher has as he works with the data. Such memos may record anything that attracts the researcher's attention during the initial phases of the analysis.

Table 1

Interview transcript	Open coding
I suppose most people need counselling at some point in their lives. I would think that some nurses are quite good at it. They have the skills. Although I'm not sure if many nurses get counselling training as part of their nurse training.	Open coding Most people need counselling ... Some nurses are good at it ... They have the skills ... Not sure about counselling training in nurse education ...

Stage two

Transcripts are read through and notes made, throughout the reading, on general themes within the transcripts. The aim, here, is to become immersed in the data. This process of immersion is used to attempt to become more fully aware of the 'life world' of the respondent; to enter, as Rogers (1951) would have it, the other person's 'frame of reference'. Examples of such notes could include:

- There are lots of different sorts of counselling being described in these interviews,

Stage four

The list of categories is surveyed by the researcher and grouped together under higher-order headings. The aim, here, is to reduce the numbers of categories by 'collapsing' some of the ones that are similar into broader categories. For example, it may be decided that the following categories are all collapsed into one category entitled 'Counselling Training for Nurses':

- Some nurses have counselling training,
- Nurses have training in counselling,
- Need for counselling training.

Stage five

The new list of categories and sub-headings is worked through and repetitious or very similar headings are removed to produce a final list.

Stage six

Two colleagues are invited to generate category systems, independently and without seeing the researcher's list. The three lists of categories are then discussed and adjustments made as necessary. The aim of this stage is to attempt to enhance the validity of the categorising method and to guard against researcher bias.

Stage seven

Transcripts are re-read alongside the finally agreed list of categories and sub-headings to establish the degree to which the categories cover all aspects of the interviews. Adjustments are made as necessary.

Stage eight

Each transcript is worked through with the list of categories and sub-headings and 'coded' according to the list of categories headings. Coloured highlighting pens can be used here to distinguish between each piece of the transcript allocated to a category and sub-heading. Examples of the way such colours could be used are as follows:

- Definitions of counselling: blue,
- Patients' needs for counselling: red,
- Counselling and nurse training: green.

Alternatively, these categories can be identified on a computer, using a wordprocessor and a coding scheme devised by the individual researcher (Table 2).

Stage nine

Each coded section of the interviews is cut out of the transcript and all items of each code are collected together. Multiple photocopies of the transcripts are used here to ensure that the context of the coded sections is maintained.

Table 2

Transcript	Categories
Counselling, for me, is a question of helping people to sort out their own problems in their own way.	Definition of counselling
There are other definitions, of course. This is not the only one	Definition of counselling
I would think that a lot of nurses get taught something like this during their training	Counselling and nurse training
I suppose that we were taught the non-directive approach which says that patients have to find their own solutions.	Definition of counselling

Everything that is said in an interview is said in a context. Merely to cut out strings of words, devoid of context is to risk altering the meaning of what was said. A crude example of this might be as follows. Here, the bracketed words have been cut out to leave a phrase which, on its own, clearly means something different than it does when read with the words in brackets.

[I'm not sure. I don't think that] *everyone needs counselling in nursing*, [to say that would be to exaggerate a lot. . .]

The multiple copies allow for the sections either side of the coded sections to be cut out with the coded areas. A note of caution must be sounded here. Once sections of interviews are cut up into pieces, the 'whole' of the interview is lost: it is no longer possible to appreciate the context of a particular remark or piece of conversation. For this reason, a second 'complete' transcript must be kept for reference purposes.

Stage ten

The cut out sections are pasted onto sheets, headed up with the appropriate headings and sub-headings.

Stage eleven

Selected respondents are asked to check the appropriateness or otherwise of the category system. They are asked: 'Does *this* quotation from your interview fit *this* category? . . . Does this? . . .' Adjustments are made as necessary. This allows for a check on the *validity* of the categorising process to be maintained. Another method that can be used to validate the findings is described in the next section.

Stage twelve

All of the sections are filed together for direct reference when writing up the findings. Copies of the complete interviews are kept to hand during the writing up stage as are the original tape recordings. If anything appears unclear during the writing up stage of the project, the researcher should refer directly back to the transcript or the recording.

Stage thirteen

Once all of the sections are together, the writing up process begins. The researcher starts with the first section, selects the various examples of data that have been filed under that section and offers a commentary that links the examples together. That researcher then continues on to the next section and so on, until the whole project is written up. All the time that this writing up process is being undertaken, the researcher stays open to the need to refer back to the original tape recordings and to the 'complete' transcripts of the interviews. In this way, it is possible to stay closer to original meanings and contexts.

Stage fourteen

The researcher must decide whether or not to link the data examples and the commentary to the literature. Two options are available here. First, the researcher may write up the findings, using verbatim examples of interviews to illustrate the various sections. Then, he may write a separate section which links those findings to the literature on the topic and make

comparisons and contrasts. Second, the researcher may choose to write up the findings alongside references to the literature. In this way, the 'findings' section of the research becomes both a presentation of the findings and a comparison of those findings with previous work. The first approach seems more 'pure' but the second is often more practical and readable.

In any analysis of qualitative data there is the problem of what to leave out of an analysis of a transcript. Ideally, all the data should be accounted for under a category or sub category (Glaser & Strauss 1967). In practice there are always elements of interviews that are unusable in an analysis. Field and Morse (1985), as we have noted, refer to this data as 'dross'. In order to illustrate what was not included in the analysis of the interviews in a recent study, it may be helpful to offer an example of data that were considered not to be categorisable nor considered to add to the general understanding of the field under consideration.

'I don't know, like they say, now they say it was alright, whereas before, perhaps, you wouldn't'.

Whilst the person in this example was trying to convey something it would be difficult to know what it was. As an aside to this discussion, it is interesting to note that such 'uncodable' pieces of transcript only appear to be unusable at the analysis stage. During the interviews, all of what was being said appeared to be quite coherent to the researcher.

VALIDITY

The question of the validity of this categorisation process must be considered. If, as Glaser and Strauss (1967) suggest, the aim of ethnological and phenomenological research is to offer a glimpse of another person's perceptual world, then the researcher should attempt to offset his own bias and subjectivity that must creep through any attempt at making sense of interview data. Two methods of checking for validity can be recommended here. First, the researcher asks a colleague who is not involved in

any other aspect of the study but who is familiar with the process of category generation in the style of Glaser and Strauss, to read through three transcripts and to identify a category system. The categories generated in this way are then discussed with the researcher and compared with the researcher's own category system. If the two category analyses prove to be very similar, at least three possibilities exist:

- a) the original category analysis was reasonably complete and accurate,
- b) the original category analysis was too broad and general in nature and thus easily identified and corroborated by another person,
- c) the colleague was anticipating the sorts of categories that the researcher may have found and offering the researcher 'what he wanted to hear'.

The last possibility can be reasonably ruled out if the colleague is unfamiliar with the subject and content of the study prior to being asked to help validate the category system.

The question of whether or not the category system is too broad and general in nature may be countered by the fact that the system described here encourages a 'funneling' process — many categories are generated at first and these are then distilled down to a smaller number by the process of 'collapsing' described above. It is to be hoped, therefore, that the agreement of two independent parties over the category system helps to suggest that the system has some internal validity.

The second check for validity is that of returning to three of the people interviewed and asking them to read through the transcripts of their interviews and asking them to jot down what they see as the main points that emerged from the interview. This produces a list of headings which can then be compared with the researcher's and the two lists can be discussed with the respondents. Out of these discussions, minor adjustments may be made to the category system.

This paper has offered just one way of exploring and categorising qualitative data. It is likely that the method could be used with a range of

types of data — from interview transcripts to articles and papers. It combines elements of content analysis with aspects of the grounded theory approach suggested by Glaser and Strauss. One of the difficulties in this sort of work is always going to be finding a method of presenting findings in an honest and reliable way. Arguably, the only real way of presenting interview findings without any sort of manipulation would be to offer the interview transcripts whole and unanalysed. This, clearly, would not be satisfactory and the reader of those transcripts would have to find his own way of categorising what was read. The method suggested here is one that stays close to the original material and yet allows for categories to be generated which allow the reader of a researcher report to 'make sense' of the data.

CONCLUSION

The issue of how to analyse qualitative data remains a thorny one. This paper has identified one method of attempting such analysis but has also identified some of the many problems associated with the process. It is stressed that this is just one way to analyse data and that the method must be used cautiously and with constant awareness of possible problems. It is asserted that the researcher needs to be both systematic and alert to the complexity of the task. On the other hand, the researcher must start somewhere — attempts must be made to represent the thoughts and feelings of others in a systematic but honest way. This paper has offered one such method.

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Appendix 4: Inform Consent

Informed consent form

In signing this document, I am giving my consent to be interviewed by a PhD student of University of Wales College of Medicine (UWCM). I understand that I will be part of a research study that will focus on the exploration of the quality of maternity care regarding postnatal depression in Greece. It is believed that this study will enable health – care providers to better meet the needs of women. I understand that my opinion and experiences are very important and are needed to give an accurate picture of the maternity care provided in Greece.

I understand that I will be interviewed with my full concern. The interview will take place at any time any place I choose. I understand that I have the right not to answer any particular question that I don't feel comfortable with. However, if I have any comments or concerns about any question, I am free to ask. I understand that the researcher will use audio recorder during the interview which, I have the right to deny. I also understand that the researcher may contact me for more information in the future.

The interview was granted freely. I have been informed that the observation is entirely voluntary, and even after the interview begins I can decide to terminate it at any point. I have been told that the context of the interview will not be given to anyone else and no reports of the study will ever identify me in any way. I have also been informed that my participation or refusal will have no effect on me or any member of my family. I also understand that there will be no direct benefit as a result of my participation.


I understand that the results of this study will be given to me if I ask for them and that Miss Maria Leondari is the person to conduct if I have any questions about the study or about my rights as a study participant. Maria Leondari can be reached through her e-mail leondarim@cardiff.ac.uk.

.....
Date	Participant's Signature

	Researcher's Signature

Appendix 5: Conccent Letter

**Appendix 6: Ethical Approval (Original copy from the place where
the study was conducted)**


ΕΛΛΗΝΙΚΗ ΔΗΜΟΚΡΑΤΙΑ
Πε.Σ.Υ. ΗΠΕΙΡΟΥ
ΠΑΝΕΠΙΣΤΗΜΙΑΚΟ ΓΕΝΙΚΟ
ΝΟΣΟΚΟΜΕΙΟ ΙΩΑΝΝΙΝΩΝ
ΕΠΙΣΤΗΜΟΝΙΚΟ ΣΥΜΒΟΥΛΙΟ
 Τηλ.: 98519

Ιωάννινα 12-12-2003
 Αριθ. Πρωτ.: 453

ΠΡΟΣ: Το Συμβούλιο Διοίκησης του
 Νοσοκομείου

ΚΟΙΝ: Α. Δημητρίου, Δ/ντρια Νοσηλευτικής
 Υπηρεσίας.

ΘΕΜΑ: « Έγκριση ερευνητικού πρωτοκόλλου».

ΣΧΕΤ : Το υπ' αριθμ 359/6-11-03 έγγραφο της κας. Α. Δημητρίου Δ/ντριας Νοσηλευτικής
 Υπηρεσίας.

Σας θέτουμε υπόψη τα παραπάνω σχετικό έγγραφο και σας κάνουμε γνωστό ότι το Ε.Σ.
 με την αριθ. 19/3-12-03 (θ.:4γ) απόφασή του και αφού έλαβε υπόψη τη σύμφωνη γνώμη της
 Επιστημονικής Επιτροπής Έρευνας, το ερευνητικό πρωτόκολλο που υπεβλήθη από την κα. Α.
 Δημητρίου Δ/ντρια Νοσηλευτικής Υπηρεσίας
 Η μελέτη έχει τίτλο: « Η διερεύνηση της ποιότητας της Μαιευτικής φροντίδας, σε σχέση με την
 επιλόχεια κατάθλιψη στην Ελλάδα».

Η ενδιαφερόμενη Λεοντόρη Μαρία (ΤΕ Μαία) που θα προβεί στη συλλογή δεδομένων για
 την πραγματοποίηση της εν λόγω μελέτης είναι φοιτήτρια στο τμήμα Νοσηλευτικών κα
 Μαιευτικών σπουδών του Παν. Ιατρικής Σχολής της Ουαλίας για απόκτηση διδακτορικού
 διπλώματος PhD.

Στόχος της μελέτης είναι να ερευνήσει την ποιότητα της παρεχόμενης Μαιευτικής φροντίδας
 σχετικά με την επιλόχεια κατάθλιψη στην Ελλάδα.
 Ως μέθοδοι συλλογής δεδομένων θα χρησιμοποιηθούν η παρατήρηση καθώς και οι ημι-
 δομημένες συνεντεύξεις σε Μαίες Μαιευτήρες –Γυναικολόγους του Νοσοκομείου μας.

Τα πιθανά αποτελέσματα αυτής της μελέτης θα παράσχουν τα κριτήρια αξιολόγησης που θα
 μπορούσαν να χρησιμοποιηθούν ως βάση για την κατασκευή ενός εργαλείου μέτρησης για την
 ποιότητα της Μαιευτικής φροντίδας ως προς την επιλόχεια κατάθλιψη.
 Η Μαιευτική αυτή μελέτη δεν πρόκειται να επιβαρύνει οικονομικά το Νοσοκομείο και η διεξαγωγή
 της θα πραγματοποιηθεί δωρεάν.

Το ως άνω πρωτόκολλο είναι πλήρες και καλύπτει τους κανόνες ηθικής και δεοντολογίας.

Επίσης το Ερευνητικό πρωτόκολλο θα πρέπει να πραγματοποιηθεί σύμφωνα με τα όσα ορίζονται
 στον Κανονισμό διενέργειας ερευνητικών πρωτοκόλλων του Νοσοκομείου μας.

Κατά την συζήτηση του θέματος στο Επιστημονικό Συμβούλιο έλαβαν μέρος:

Ε. Ζερβού, Διευθύντρια Αιμοδοσίας. Μέλη: Κ. Μπουραντίς Καθηγητής Παθολογίας -
Αιματολογίας, Π. Νικολόπουλος Αν. Διευθ. Ακτινολογίας, Β. Σιόντη ΤΕ Νοσηλευτριών
Προισταμένη Χ/κού Τομέα Νοσ Υπηρεσίας, Ε. Τσιάνος Καθηγητής Α Παθολογικής Κλινικής,
Γ. Κολιάς ΠΕ Χημικός-Βιοχημικός.

Η Πρόεδρος του Ε.Σ

Ε. Ζερβού
Διευθύντρια Αιμοδοσίας

