

2009

An exploration of the experiences leading to volunteer facilitation of postnatal depression peer support groups

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An Exploration of the Experiences Leading to Volunteer Facilitation of Postnatal
Depression Peer Support Groups.

Tracey Parker

A report submitted in Partial Fulfilment of the Requirements for the Award of Bachelor of
Arts (Psychology) Honours, Faculty of Computing, Health and Science, Edith Cowan
University.

Submitted May 2009

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Abstract

In recent years literature regarding peer support recovery services has been more prominent. However, little attention has been paid to how these services are used to treat postnatal depression and questions regarding what informs a consumer's decision to become a support person to others remain. The aim of this study was to explore women's postnatal depression and how their experience and recovery informed a decision to become a peer support group facilitator. Participants were eight women who were past or current facilitators with the Post Natal Depression Support Association Inc. (PNDSA). In-depth conversational style interviews were conducted with participants and a thematic content analysis was performed on the resulting interview transcripts. The main motivational factor behind the decision appeared to be empathy derived from women's own experiences. Women described symptoms of burnout and a loss of empathy as challenges of facilitating and reasons for discontinuation of the role. Future research may need to clarify the experience of loss of empathy in relation to facilitator's own recovery.

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Submitted: May 2009

Acknowledgements

I would like to thank the eight wonderful women who shared their stories so generously with me and the 2008/2009 PNDSA Committee who supported this research from its very inception, through to the final product.

Many thanks must also go to Dr Elizabeth Kaczmarek who kept me on track and was a source of invaluable support and information. Thank you for seeing me through this long but ultimately rewarding experience.

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An Exploration of the Experiences Leading to Volunteer Facilitation of Postnatal Depression Peer Support Groups.

The expression Postnatal Depression (PND) is assumed to describe the difficulties that affect approximately 18% of childbearing women (Maloney, 1998). Typically, women report cognitive and behavioural symptoms associated with depression, however, whilst the disorder is recognised (DSM-IV-TR; American Psychiatric Association [APA], 2000), debates exist with respect to the psychosocial nature of PND (Hanley & Long, 2006). The feminist literature tends to view PND as a response to an experience that drains heavily on an individual's personal resources, rather than as a mental illness (Mauthner, 1998).

Treatment options to facilitate recovery are many and include medication and/or psychological interventions depending on individual need (Kopelman & Stuart, 2005). 'Recovery' may be a state in which symptoms are lessened, to an extent where an individual can resume daily functioning at what would be considered a normal level (Davidson, O'Connell, Tondora, Lawless, & Evans, 2005). However, others argue that recovery is a process rather than an outcome and is not synonymous with 'cure'. Far from simply returning to a previous state of functioning, a process of growth may take place where an individual is empowered to make changes and develop new coping skills (Frese & Walker-Davis, 1997).

While antidepressant medication has been found to be an effective treatment for PND (Misri & Kendrick, 2007), many women are reluctant to take it, particularly if breastfeeding (Boath, Bradley, & Henshaw, 2004). A number of psychological treatment options provided by counsellors and mental health professionals, as well as trained lay support people are available, including individual and group therapy and peer support (Kopelman & Stuart, 2005). Studies have found that support offered by peers who have had similar experiences, is effective in assisting women in their recovery (Dennis, 2003). Typically these support services are provided by non-profit consumer organisations staffed by volunteers and are aimed at guiding women through the process of 'recovery' by offering hope and empowerment (Corrigan, Slopen, Gracia, Phelan, Keogh & Keck, 2005).

The volunteerism literature debates why individuals who have reached a state of recovery themselves, choose to volunteer in a support role. Studies have found that far from being purely altruistic, motivation for volunteering is often based in the benefits to the volunteer (Wilson & Musick, 1997; Wilson, 2000) including self-development, self-esteem enhancement and career advancement (Greenslade & White, 2005; Thoits &

Hewitt, 2001); increase in overall life satisfaction (Thoits & Hewitt, 2001) and facilitation of recovery from mental illness (Osborne, Ziersch & Baum, 2008).

However, there is limited research that examines the experiences of women who have overcome PND and how they became involved in peer support. Therefore, the aim of this study is to identify what it is about women's experiences of PND and the recovery process that has led them to offer peer support in a group facilitator role.

Postnatal Depression (PND) Overview

Definition, prevalence and risk factors

The transition to parenthood is socially constructed as a joyous and fulfilling life experience for both mothers and fathers (Lewis & Nicolson, 1998), however the emotional well-being of mothers in the postnatal period is at risk, due to the various and sometimes stressful life changes that women may experience following birth (Horan-Smith & Gullone, 1998). There is a wealth of literature discussing this transition, from both medical (Yim, Glynn, Dunkel Schetter, Hobel, Chicz-DeMet & Sandman, 2009) and social perspectives (Morse, 1993) as well as studies from a feminist viewpoint (Mauthner, 1998), which attempt to pinpoint the causes of distress for the mother.

In the week following birth, anywhere from 20-75 % of women will suffer from the "baby blues", a mild mood disorder marked by anxiety, depressed mood, fatigue and poor concentration which is of a transient nature and usually subsides within two to three days (Edhborg, Matthiesen, Lundh, & Widström, 2005). In a study of women in Western Australia, Maloney (1998) found that approximately 18% of women could be identified as suffering PND, often described as the baby blues that will not go away.

Postnatal depression is clinically defined as a non-psychotic depressive illness, with symptoms similar to typical major depressive episodes (Boyce, 2003; Edhborg et al., 2005) including feelings of inability to cope, fear, anxiety, anger and loss of enjoyment of social contact or physical pleasure (Pope, Watts, Evans, McDonald, & Henderson, 2000). PND usually develops within the first four to six weeks following childbirth and without adequate treatment, may persist for many months and sometimes longer (Pope et al., 2000).

Long term PND has been found to have a detrimental effect on infant bonding, child development and parent-child relationships, as well as maternal emotional wellbeing following subsequent births (Morse, 1993). Philipps and O'Hara (1991) recruited 70 women and followed them from the third trimester of pregnancy through to four and a half years postpartum. Their findings indicated that women who had experienced PND were at significant risk for subsequent episodes of depression, which

can have a detrimental effect on their relationship with their partner and children and have consequences for the family unit.

Research into early child development has found that interacting with and talking to infants, reading books and following routines are important tasks in fostering the bonding process between parent and child. In a study incorporating 1871 mothers, McLearn and colleagues (2006) found that mothers who were depressed were less likely to engage in interactive play with their infants. Such interaction is believed to relate to a resulting secure attachment between parent and child. However in cases where depressive symptoms are evident, parents may react with indifference or low sensitivity to their baby's needs creating an avoidant or anxiously attached infant. The inability to identify different types of crying or to tolerate an infant's crying at all, can lead to delayed attentiveness from which an infant will learn that even prolonged crying will not always lead to a response from their caregiver. In these instances, a secure base has not been provided for the child to turn to for comfort (Morse, 1993). The resultant poor attachment may increase the risk of behavioural, psychological and cognitive difficulties for the child (Abrams & Curran, 2007). In turn, the disparity seen in these attachment styles can lead to further feelings of distress for the parent in the form of helplessness and incompetence (Morse, 1993).

Meta-analyses and reviews of the literature provide an exhaustive list of risk factors for postnatal depression including, but not limited to; lack of social support, previous psychiatric history, significant life events and unplanned pregnancy (Horan-Smith & Gullone, 1998; Boyce, 2003; Lusskin, Pundiak, & Habib, 2007). Pope and colleagues (2000) categorised risk factors as 'confirmed', 'probable' and 'possible' as a result of their review. Confirmed factors included personal history of depression, antenatal depression, difficulty in marital relationship, lack of support and stressful life events. The literature however, is generally inconsistent in reporting the significance of socio-demographic factors, such as age, employment and marital status (Boyce, 2003). It is worth noting that lack of support either socially in the wider community or in familial circles is a risk factor that continually arises in both quantitative and qualitative studies of PND. In addition, marital problems have been identified as a risk factor in many studies (Abrams & Curran, 2007; Boyce, 2003). Marital difficulties may not only contribute to, but also be a product of, the presence of PND in the transition to parenthood (Whiffen & Gotlib, 1993).

In a qualitative study undertaken by Mauthner (1998), women reported experiencing a lack of support and isolation from other mothers with young children,

their partners, family and friends. Much of this isolation stemmed from fear of discussing their feelings with others, as they did not want to look like a 'bad mother'. A study by Lewis and Nicolson (1998) where twelve mothers at risk of depression were interviewed regarding their experience of being a mother, found that the popular construction of postnatal depression as a mental illness may not be appropriate in the context of how women relate their parenting difficulties. Women described their experiences of birth and the transition to parenthood as a series of losses; of identity, expectations and power. In this sense, the term postnatal depression can be used to explain these negative feelings and experiences, which may in fact be normal reactions to a difficult period of adjustment rather than a medical condition, as such.

Treatment and outcomes

A variety of traditional treatment options are available for women with PND, including medication and forms of individual or group therapy or counselling, however the literature is inconclusive on whether singular or combined treatments are most effective (Hanley & Long, 2006). Although some evidence indicates that anti-depressant medication can be effective in treating PND, a study by Pearlstein and colleagues (2006) found that women's treatment preferences were influenced by breastfeeding. Medication was chosen as a treatment less frequently by women who were breastfeeding, signifying a concern that the drugs may be harmful to their baby (Kopelman & Stuart, 2005). Research findings into the safety of anti-depressant use by breastfeeding mothers are ambivalent, with studies suggesting they should not be used as an initial treatment method, until the effects on the developing infant are known (Stuart, O'Hara, & Gorman, 2003). Such a recommendation would be dependent on the severity of each individual woman's symptoms and a risk-benefit assessment, taking into account efficacy of medication, risk of not treating and risk to the infant would need to be undertaken (Pearlstein, 2008).

There is empirical support for the use of psychological interventions as a first treatment approach for PND. In particular interpersonal psychotherapy (IPT) and cognitive behaviour therapy (CBT) have been found to be efficacious (Kopelman & Stuart, 2005). IPT attempts to alleviate symptoms of depression by assisting individuals to make changes in their relationships and to address role change, social support and marital issues. A pilot study by Reay and colleagues (2006) involving 18 women who attended eight, two hour IPT sessions found that marital relationships were improved and depressive symptoms lessened.

Therapists using CBT interventions work with individuals or groups to address their cognitions or thought patterns about the world, about themselves and in this case, about motherhood (Meager & Milgrom, 1996). A meta-analysis undertaken by Bledsoe and Grote (2006) reported that a combination of anti-depressant medication and CBT had the largest effect in treating PND compared with group therapy and IPT among other treatments.

Support offered by non professional people is increasingly being seen as effective in treating PND. Evaluations of peer support programs have found that mothers are accepting of the support they receive from peers and have found this support useful in their recovery (Kopelman & Stuart, 2005). An evaluation of the Visiting Moms Program in the United States, surveyed mothers who had used the service and found that 98% were satisfied with the support received from their home visitor. Mothers also reported a positive change in their feelings around being a mother and a decrease in their feelings of isolation as a result of the program (Paris, Gemborys, Kaufman, & Whitehill, 2007). A qualitative study into women's perspectives on PND found that "it was often through talking to, and finding that their experiences resonated with another mother that they began to recover, partly because these relationships allowed and enabled them to openly question, if not resist, the ideals of motherhood they had struggled to fulfil" (Mauthner, 1998, p. 346).

Recovery

Recovery from PND is somewhat difficult to define and operationalise as the literature describes a process of recovery that entails more than just symptom reduction, as would be defined in the medical model (Roe & Chopra, 2003). Although important and achievable (Kopelman & Stuart, 2005), symptom reduction is but one aspect of the new concept of recovery in mental health. It is widely accepted that recovery is not a linear process, rather one with progress and setbacks alike (Higgins & McBennett, 2007) which may in fact take place even when symptoms still exist (Anthony, 1993). In this sense, recovery is not the same as cure; it is a process, not an outcome (Meehan, King, Beavis, & Robinson, 2008). Terminology needs to be clarified so as not to give false hope of complete recovery, which may not be possible for all people, but to promote a sense of hope for a more fulfilling and socially active life (Davidson, et al, 2005; Ramon, Healy & Renouf, 2007).

Recovery may also involve an individual discovering hope following a period of despair and reaching a state of acceptance, engagement and active coping (Ridgway, 2001). Brown and colleagues (2008, p. 168) define recovery as the creation of a new

state of wellness “by developing new capacities that can be used to achieve new goals.” Goal setting is another avenue by which a sense of hope is engendered in an individual. By setting and achieving goals of wellness, individual’s harness their own problem solving ability and capacity to continue with life, over and above the perceived and actual limitations of their psychological concerns. The consumer literature identifies gaining control over one’s life as an important part of recovery rather than the absence of symptoms used as outcome indicators in clinical studies (Ramon, et al., 2007).

Davidson and Roe (2007) discuss the concept of “recovery in” as opposed to recovery from mental illness. They posit that this concept does not assume a return to previous or normal functioning, rather that individuals might overcome aspects of their situation such as loss of identity, isolation, loss of sense of self and purpose and the traumatic effects of being treated for a mental illness. They state that a return to previous levels of functioning may indeed be impossible and that attention should be given to the changes and growth that have taken place in an individual’s efforts to manage and therefore potentially overcome their mental illness. Alternatively, an individual may be able to achieve a previous state of functioning in some aspects of their lives, but not in others.

Jacobsen and Greenley (2001, cited in Happell, 2008, p. 117) separated issues experienced by consumers in the recovery process into two domains; internal and external. In this model, internal conditions were empowerment, connection, healing, and hope and external conditions were related to a culture of healing, human rights and recovery based services. A study by Happell (2008) which explored the views of mental health consumers in relation to recovery, found that support from peers was a major influence and an important factor in recovery. Participants stated that they benefitted from the opportunity to be with others who had a personal understanding of the issues they were facing.

Maloney (1998) describes the experience of PND as a transition from both emotional and physical upheaval to what she terms ‘stable motherhood’, which is characterised by a feeling of calm and balance in the role of mother, wife or partner and person. In this qualitative study involving fifteen mothers with PND, participants reported feeling vulnerable and sensitive to criticism and that support in all its forms from practical to emotional as provided by family or professionals, was an important part of reaching ‘stable motherhood’. Attaining this stability also involved the resolution of role conflicts in the transition to parenthood. In the recovery process,

women are more able to accept themselves and abandon their ideal of the perfect mother (Mauthner, 1995).

Consumer run/peer support services

Support offered by consumer run or peer support organisations is becoming increasingly popular as an alternative treatment method to mainstream health services (Nelson, Ochocka, Griffin, & Lord, 1998). Such organisations are assumed to be run by those who have reached a state of, or are “in recovery” from a similar set of symptoms and offer a message of hope to those currently seeking support (Lefley, 1997).

Consumer volunteers’ activities are many and varying, including public education, facilitating support groups and consumer representation (Brown et al., 2008).

Who volunteers and why?

Wilson (2000, p. 215) defines volunteer work as “any activity in which time is given freely to benefit another person, group, or organization”. In Australia, 32% of the adult population volunteer on an annual basis and it is this workforce that keeps the not-for-profit sector operating (Greenslade & White, 2005). A volume of research covers the demographics of those who are most likely to volunteer in such organisations. In general the literature reports that well educated, middle class women are most likely to volunteer, particularly in middle age when their children are at school (Osborne, et al., 2008; Thoits & Hewitt, 2001; Wilson, 2000; Wilson & Musick, 1997). Research conducted by Osborne and colleagues (2008) found that a flexible employment situation, partner support, university education and socioeconomic advantage were all factors that made it easier for women to remain in volunteer work despite the demands of work, children and other activities.

Rotolo (2000) asserts that the position of an individual in the life cycle will have an impact on their decision to volunteer. For example the transition to parenthood may have a negative impact on a woman’s intent to volunteer initially, however when her children are of school age there may be more incentive to volunteer in school based groups such as the parents and teachers association.

In the functional theory approach to volunteerism, the decision to volunteer occurs when one or more of six motivations are fulfilled. These motivations include the expression of altruism; an attempt to gain an understanding of those being helped; the attainment of career benefits; the expression of social norms or influence of friends and family; the attempt to reduce guilt associated with being more fortunate than others; and the attempt to promote self-esteem and personal development. This theory was tested by Greenslade and White (2005) in a study where 81 volunteers completed questionnaires

regarding their volunteering experiences and motivations to determine what factors might facilitate above average participation in volunteerism. The results indicated that only the social function or expression of social norms was a significant predictor, an inconsistent finding compared to past research which suggested the social function was of least importance (Clary, Snyder, Ridge, Copeland, Stukas & Haugen, 1998).

As well as motivational factors, personality attributes have been studied in relation to volunteering. Results of an Australian study (Elshaug & Metzger, 2001) which used the five factor model of personality to measure differences in personality between volunteer and paid workers in similar occupations indicated that extraversion and agreeableness and particularly the attributes of warmth, positive emotions, trust and altruism, were characteristic traits of those who volunteer. People who volunteer may generally be those who are helpful and seek the company of others. The authors suggest that organisations take these findings into account when advertising for new volunteers, highlighting the benefits of helping others and the social aspects of the volunteering role to enhance the likelihood that the interest of potential volunteers will be piqued.

The Community Mothers program in Western Australia involves home visiting by volunteers to new parents in an effort to build confidence and improve outcomes for children. Volunteers are mothers who are trained and given support by community nurses to offer support, encouragement and information to families in their own homes. An evaluation of the program by Downie, Clark and Clementson (2005) identified three main themes as to why volunteers became “community mothers” namely; empathetic concern, contribution to community life, life-course issues and personal development. Firstly, volunteers demonstrated empathy for new parents in response to their own negative experiences of motherhood, specifically isolation, lack of support and PND. Secondly, volunteers had a genuine urge to offer assistance to other people by utilising their own skills, experience and caring natures. Thirdly, participation in the program gave volunteers an opportunity to improve their listening skills and a sense of personal fulfilment in knowing that they have been helpful to parents. Volunteers also cited increased confidence and empowerment as outcomes of their home visiting experience. The authors also state that the most committed volunteers seem to be those who have had personal experiences of difficulty in their own transition to parenthood even though their own children are now older (Downie, et al., 2005).

Unfortunately, with continued volunteering particularly in support roles, burnout can occur. This may lead to a withdrawal of participation by even the most committed volunteers. This phenomenon can be described as a psychological syndrome where

emotional exhaustion, depersonalisation and feelings of negativity towards one's work are prominent. Those working in the human services are thought to be of particularly high risk for burnout. Burnout can occur due to the emotional, physical and time demands placed on a volunteer as well as lack of involvement in decision making, problems with clients and role uncertainty (Bakker, Zee, Lewig, & Dollard, 2006). In addition, the quality of training, volunteer management and personal satisfaction with one's work are other factors that affect volunteer turnover (Skoglund, 2006).

Peer support programs for PND

Consumer run organisations operate from a recovery model that empowers the individual to use coping strategies, to effectively treat themselves. They deliver a message of hope that recovery can be attained and work towards destigmatisation of the disorder they are targeting. The emphasis of this recovery model is that consumers have the ability to make their own decisions and solve their own problems, with the support and expertise of their recovered peers. Often with support from consumer role models, individuals will eventually take on a productive role in a consumer organisation which enables them to help others, but also strengthens and maintains their own recovery (Anthony & Ashcraft, 2006).

A study by Scrandis (2005) investigating the use of social supports by women with PND found that normalisation of their depressive symptoms was important to their recovery. Women sought out other mothers to determine what a normal postnatal experience was and found that the mutual empathy and empowerment they encountered when interacting with mothers who had similar experiences, gave them perspective and helped them to cope. Alternatively, women whose support systems lacked empathy reported more negative feelings of self-worth and increased depressive symptoms. This lack of understanding also led women to discredit their own symptoms telling themselves "I should be happy". Many women also reported unsatisfying interactions with their health care providers, who they felt often showed a lack of understanding and empathy. Nelson and colleagues (1998) assert that many consumer organisations have been formed in part due to the negative experiences people have had with mainstream health services, in particular with the mental health system. For example, the 1970's American consumer movement was borne out of the denial of basic human rights, when people were frequently forcefully hospitalised for mental illness and discriminated against because of that label (Frese & Davis, 1997).

Dennis (2003) recruited forty two mothers considered at risk of PND and randomly assigned them to either a treatment or control group. The treatment group

received peer support in the form of telephone contact over an 8 week period. Results indicated that there was a significant effect of peer support on the depressive symptoms of mothers at four and eight weeks. It was determined that the quality of peer support rather than the length of interaction was the most important factor in achieving improved health for the women. Dennis also postulates that the knowledge that a peer was available to talk to if needed, may have had a positive effect on the women.

The Sutherland Family Network, a volunteer home visiting program in Sydney, provides support to new mothers with either physical or emotional isolation, or depression. In a qualitative paper evaluating the program, 15 mothers were interviewed and their experiences analysed into thematic descriptions. Overall, mothers reported valuing the volunteers for the emotional support and friendship that they offered. They also felt more comfortable with, and trusted other mothers more than their professional counterparts. Mothers were comforted to know that there was someone who cared without the concern of having children removed if they were perceived as 'not coping' (Taggart, Short, & Barclay, 2000).

In Western Australia the Postnatal Depression Support Association Inc. (PNDSA) offers group and telephone support for women suffering PND in the metropolitan area of Perth. The groups are run by volunteers who have experienced PND and their own process of recovery. The group facilitators undergo training in mental health issues surrounding pregnancy, childbirth and motherhood, as well as listening and counselling skills. Combined with personal experience, this training enables facilitators to provide a unique and empathetic service to the women of Western Australia (Post Natal Depression Support Association, 2006).

Utilising the peer support recovery model, the aim of the support groups is to offer a safe environment for women to discuss their feelings and issues with other mothers and group facilitators who have empathy for their situation (Post Natal Depression Support Association, 2005). Mothers are able to normalise their symptoms and use the expertise and hope offered to them by their peers to begin their own journey of recovery. Consumer run organisations such as the PNDSA are able to offer unique peer relationships to people, as the sharing of similar experiences is important to supportive relationships. The sense of belonging, validation of feelings and reduction in feelings of isolation felt by participants are indicative of the effectiveness of peer support, as well as the empathy and emotional aspect brought to the organisation by peers (Brown et al., 2008). The social support offered to women through the support

groups is particularly important in a society where the network of close family members does not always exist (Paris et al., 2007).

Research limitations and recommendations

The current research into PND is very comprehensive and is continuing to evolve. However, many studies are quantitative and medical in nature and fail to address the stories of the individuals whose lives are affected (Hanley & Long, 2006; Mauthner, 1998). To be able to understand and therefore effectively treat PND, more qualitative research needs to be undertaken to inform those in the mental health profession, as well as policy makers, about the needs of these women and their families. Allowing women to talk openly about their experiences may also be beneficial in lifting the stigma associated with issues that are popularly considered to be mental health problems.

Literature regarding consumer run organisations and peer support models of recovery has been more prominent in recent years (Brown, et al., 2008; Frese & Davis, 1997; Lefley, 1997). However, little work has been produced that qualitatively assesses the use of peer support as a treatment method for PND specifically. Studies have generally stated that peer support in mental health is a useful treatment tool (Nelson et al., 1998; Scrandis, 2005), however have not looked at what women say about being involved in a consumer organisation, either as a client or volunteer support person. Questions regarding what informs a consumer's decision to become a support person to others remain. At this point in time there is limited knowledge about recovery from PND and how or why this underpins a decision to volunteer. An understanding of why and how people come to volunteer may assist consumer organisations to prevent burnout and find new ways of recruiting and retaining their workforce.

The aim of this study is to explore women's own accounts of their lived experiences and perceptions of these experiences. Therefore the research question is: how did the experience of and recovery from postnatal depression inform women's decisions to become a peer support group facilitator?

Method

Research design

This qualitative study was designed to explore women's experiences and individual perspectives on recovery from PND and facilitating a peer support group. The naturalistic paradigm in qualitative research holds that people have different perceptions and experiences and has an interpretive approach to these varying world views (Creswell, 1994). As such, women's experiences and perceptions of their PND,

recovery process and volunteer facilitation were explored using a phenomenological approach, where the main concern was the lived experiences of the women involved. This theoretical framework was adopted in an effort to understand the social and psychological phenomena associated with PND and the decision to become a volunteer facilitator, from the participants' perspective. (Groenewald, 2004).

Use of the qualitative approach allowed the complexity of perceptions and concepts surrounding the women's experiences to be understood in context. The aim of the design was to obtain meaning from the women's responses through an inductive process of data analysis (Creswell, 1994).

The researcher's own personal experiences and long tenure as a support group facilitator lent a theoretical sensitivity (Strauss & Corbin, 1990) to the data collection process as well as enabling a holistic capturing of information through the conversational style interviews (Lincoln & Guba, 1985).

Participants

Participants were eight women who were current or past PND support group facilitators with the Post Natal Depression Support Association Inc. (PNDSA), living in the Perth metropolitan area. Table 1 outlines participant demographics.

Table 1

Participant Demographics

Pseudonym	Age	Children/Ages	Length of service
Jenny	36	3 aged 7, 8, 12	4 months
Fiona	38	2 aged 5, 8	5 years
Donna	38	4 aged 2, 12, 13, 15	2 years
Emily	41	2 aged 8, 10	6 years
Linda	42	2 aged, 3, 14	18 months
Kathy	45	1 aged 13	3 years
Rachel	46	3 aged 7, 9, 12	6 months
Susan	49	2 aged 18, 21	3.5 years

The participants were aged between 36 and 49 years. The number of children ranged from one to four children, whose ages ranged from two to 21 years, including non-biological step-children. Participants had volunteered with the PNDSA for between four

months and 6 years, three of whom were current group facilitators and five of whom were past facilitators volunteering in other roles within the organisation, or who were no longer associated with the group. The majority of women originated from Australia; however two women emigrated from South Africa, following the birth of their children.

Convenience sampling was employed due to the nature of the researcher's involvement with the PNDSA. Snowballing techniques were also used where participants were able to recommend others for interviewing.

Procedure

The study was reviewed by the Edith Cowan University Human Research Ethics Committee and with the support of the 2008/2009 PNDSA Executive Committee, information letters (Appendix A) were posted to five current and 12 past volunteer support group facilitators. Recipients were invited to contact the researcher if they were interested in participating. Once recruited, interviews were conducted in a place deemed convenient and comfortable for the participant.

Prior to commencement of the interview, participants completed a consent form (Appendix B) and were given the opportunity to ask any further questions. Participants were also asked to give consent to be contacted to provide feedback on the researcher's interpretations, at a later date.

Participants were also asked to complete a demographic data sheet (Appendix C), providing information regarding their age, contact telephone number, suburb, number of children and their ages and length of time spent in the volunteer role. Participants were also asked to give a brief description of what type of support they had received in their PND experience for example, therapy or self-help. This information was requested as it was deemed relevant to the literature and might aid in interpretation of the findings.

A semi-structured interview schedule (Appendix D) containing two main open-ended questions with five prompting questions was designed to facilitate an open discussion of the participants' experiences. The conversational style of the interviews enabled the researcher to gain rapport (Wengraf, 2001) and to ask further questions throughout each particular interview to gain more information or to clarify the participant's meaning. The two main questions aimed to facilitate discussion around the participants' PND experience and recovery process; and their experience of facilitating the support group. Interviews were conducted over a five week period which allowed flexibility of time to the participants and aided in transcription and preliminary data analysis by the researcher (Creswell, 1994).

Interviews were audio taped to enable verbatim transcription possible. Following each interview and on transcription of the conversation, additional thoughts or insights were noted by the researcher to aid in later analysis.

Ethics

Ethical considerations were highlighted to participants who were made aware of their right to withdraw from the study at any time and to refuse to answer any question. Confidentiality was assured and pseudonyms were applied to the interview transcripts to ensure anonymity beyond the researcher. Following the interview, participants were thanked for their participation and were given a list of support organisations that they could contact for a debriefing session, if necessary.

Data analysis

Interviews were transcribed verbatim to ensure an accurate representation of the conversation and the accuracy of data for analysis. Following the process outlined by Miles and Huberman (1984) and Creswell (1994), the information collected was analysed by reducing it to smaller units through the process of coding and then re-grouping into larger factors based on recurring ideas across transcripts and the relevant literature. A thematic content analysis was conducted using a question ordered matrix (Appendix E) (Miles & Huberman, 1984), where participant pseudonyms formed rows and the key responses to the interview questions were added in columns. This enabled commonalities to be visually displayed and subsequently grouped together to form the overarching themes and sub-themes identified as important to interpret. Triangulation was utilised to validate the data, as information from the participant demographic forms and the researchers notes were also used in the data analysis process. From this process, summary statements regarding the themes and sub-themes were formulated and defined, with supporting quotes from the transcripts identified and added (Appendix F).

On completion of the data analysis process four major themes were identified, each containing several sub-themes. Having obtained their consent to contact, two participants were randomly selected to member check the researcher's interpretations (Miles & Huberman, 1984) for verification purposes. These participants were asked to read a summary of their transcript and comment on the main points made by the researcher in relation to their experiences and perspectives (Creswell, 1994).

Creswell (1994) recommends interviews with up to ten participants to reach saturation of the data. Saturation was assumed when no additional ideas could be found that contributed to a category (Glaser & Strauss, 1967).

Findings and Interpretations

The aim of this study was to gain an understanding of women’s lived experiences of PND, how they perceived the recovery process and what it was about these experiences and perspectives that informed their decision to become volunteer support group facilitators. The study identified four main themes that appeared to relate to the decision to become a PND support group facilitator and the experiences of being a facilitator.

Table 2 contains the four main themes and related sub-themes identified from the analysis of participant’s responses: Factors contributing to PND experience, recovery journey, motivational factors and challenges of facilitating.

Table 2

PND Support Group Facilitators Identified Themes

Main themes	Sub-themes
Factors contributing to PND experience	History of depression Motherhood role perception Isolation/Perception of support
Recovery journey	Useful treatments Barriers to recovery
Motivational factors	Empathy Personal benefits
Challenges of facilitating	Empathetic exhaustion

Factors contributing to PND experience

There were three main risk factors that women attributed to their experience of PND; history of depression, perception of motherhood and the perception of support. Concurrent with the literature, there were varied accounts of causative or contributing factors; however these three sub-themes with their corresponding categories were identified as being the most commonly discussed factors.

History of depression.

The vast majority of women interviewed spoke about both a family history of depression and of experiencing personal episodes of depression prior to having children. Family history was predominantly on the maternal side, sometimes going back several generations. Therefore, some women saw themselves as having a genetic predisposition

which when combined with psychosocial factors led to the development of their PND. In contrast to the feminist literature (Lewis & Nicolson, 1998), which argues that women's experience of PND may be a normal reaction to a stressful life event, rather than an illness; women tended to see their PND as an illness, exacerbated by the stressful event of having a child. The possible reasons for this may be three-fold. Firstly, society constructs PND as a mental illness (Hanley & Long, 2006) and much of the media around depression in general describes it as such (Abrams & Curran, 2007). Secondly, women may find it relieving to perceive their PND as an illness or something that was out of their control, rather than an issue with their personality or ability to cope with stress. Emily described this phenomenon in relation to her recovery from PND:

...the turning point was that I was allowed to; it was acknowledged that I suffered from an illness, rather than a fault.

Thirdly, women described experiencing previous episodes of depression, supporting the literature which suggests that previous history of depression is a confirmed risk factor for developing PND (Boyce, 2003; Horan-Smith & Gullone, 1998; Lusskin, et al., 2007; Pope et al., 2000). Therefore women may perceive PND as another, perhaps inevitable, depressive episode given their history. However, women described their depressive symptoms following childbirth as more noticeable or more severe than previous episodes. Jenny described her experience of depression:

I wouldn't call it postnatal depression anymore, it's just depression in general that I experience, but I'm more aware of the signs, but I think it was more intense when I had the children.

This finding is incongruent with research that has found PND to be milder than typical episodes of depression seen by mental health professionals (Whiffen & Gotlib, 1993). In fact, women had previous depressive episodes that were less severe than those experienced in the postnatal period.

The contributing factor of previous history also appeared to relate to women's ability to understand the role of motherhood and what was expected of them, particularly when their own mother had also experienced depression.

Motherhood role perception.

The perception of the role of motherhood was a crucial issue for many women. In relation to the family history aspect of their experiences, difficulty with their own parenting was a defining issue for women in how they perceived the motherhood role. Difficulties surrounded some women's relationships with their own mothers and their perceptions of their own parenting, particularly when their mothers had also

experienced PND. Women described their concept of motherhood as distorted; making it difficult to know what was expected of them as mothers. Kathy discussed her experience of being mothered in the following way:

I realised I had issues with my own mother and those issues stemmed around, or were about the fact that she had been moderately to severely depressed for most of our lives...instead of her making me feel safe, I think I tried to make her feel safe, so there was quite a role reversal there.

Sarah also experienced a difficult relationship with her mother which she expressed as one of the most important factors in her difficult transition to motherhood:

My attachment to my mum was not ideal for me...I'm pretty sure she had postnatal depression from her behaviour and my memory as a child...you can't talk to mum about anything, she will just break down crying, she can't handle it.

Previous research has indicated that women's perceptions of inadequate caring by their own mothers may lead to reduced confidence in their ability to care for their baby and subsequently put them at risk for developing PND (Gotlib, Whiffen, Wallace & Mount, 1991).

Women also discussed an overwhelming feeling of responsibility and of being unprepared for motherhood. Linda described her anxiety, "I felt the job was too big, I wasn't going to be able to do it and his complete dependence on me was overwhelming". Others felt that there was too much information available to new mothers and that this caused anxiety and confusion and was lacking in the emotional aspects of becoming a parent. Emily spoke about the pressure experienced by mothers in this way:

It is really important for them (women) to understand what they're going through and I think a really big thing in society now, is, that there is so much information out there and so much pressure to be a good mother...from the media, that people buckle under the pressure.

Some women described themselves as "perfectionists" and were overwhelmed by societal pressure to be the "perfect mother". This finding supports the research undertaken by Mauthner (1998) in which mothers reported being unable to talk about their feelings for fear of looking like a bad mother. Women also tended to have high expectations of themselves and perceived that others expectations of them were also unrealistic. Linda described her difficulty as being around her partner's expectations:

His expectation of me was the same as it had been beforehand and I probably needed him to just understand that I felt I was a completely different person.

Isolation/Perception of support.

A lack of support or perceived lack of support from women's partners was an issue that arose frequently in participants' stories. Having a partner who worked long hours or who lacked understanding of what the woman was experiencing, was a major contributing factor discussed by women. Women described relationship breakdowns of which the parenting transition was a major contributing factor. This finding supports previous studies which have found that marital difficulties are both causative and maintaining of depressive episodes (Whiffen & Gotlib, 1993).

Lack of support from other family members such as parents and siblings was also an issue for women. This was either due to geographical isolation or lack of sympathy and understanding. Lack of support, either real or perceived is an issue covered widely in the PND literature (Gotlib et al., 1991; Hanley & Long, 2006; Paris et al., 2007). When women perceive that there is no supportive structure for them in this new experience and feel disconnected from those around them, their feelings of isolation increase and their subsequent psychological well-being is compromised (Mauthner, 1995; Scrandis, 2005). These feelings of disconnection and isolation were also evident in women's experiences of interacting with other mothers. Being unable to find other women who understood was an issue for some women who also found that playgroups were a source of discomfort and stress, as described by Kathy:

...I mean when I tried to go to playgroup I felt like an alien, all these beaming mothers and I just felt terrible all the time.

Fiona also found it difficult to attend a mothers group where she perceived that her feelings were not normal as compared to other mothers. She described not being able to relate to the other mothers and that there was competition between them. This finding supports the qualitative study by Mauthner (1998) where women also reported a lack of support and isolation from other mothers. Women perceived that the mothers they encountered in these groups were all "coping" and that their own feelings were not normal. This finding may also point to why women tend to find peer support groups helpful. Susan summed up her experience of the lack of support for PND in the following way:

So that was my experience of PND, there was no support, there was no help, I was never put on medication, I felt I'd gone nuts...I was a teacher who'd managed a class of forty children and I couldn't manage this one child on my own. I mean I was just; I really thought that I'd lost it.

Recovery journey

The second major theme that emerged through analysis of the participants' stories related to the process of recovery from PND. Overall, women saw recovery not as an outcome but an ongoing process, consistent with research by Meehan and colleagues (2008). Some women described the recovery process as never-ending and detailed their continued depressive episodes or "melancholic moods". Fiona described recovery as such:

I see it as a scarring. Just like if you have a physical injury, your body will always have a history of that event and I think the same is with an episode like this, a major episode, you are scarred psychologically. I think it's a matter of letting go of a lot of things, and acceptance that you were unwell and that you can improve yourself and there is in the future, the increased possibility of another episode...you have to be prepared for that.

These findings support literature regarding recovery oriented services which assert that recovery is an ongoing process where progression and setbacks are expected (Higgins & McBennett, 2007) and that the goal is symptom management rather than cure (Anthony, 1993; Davidson et al., 2005). The concept of "recovery in" as opposed to "recovery from" as discussed by Davidson and Roe (2007) could be applied to the women's accounts of their recovery process. Although many women continue to experience depression, they have been able to manage it and have developed coping skills as described by Linda:

I think these periods where I feel really melancholic, I don't see that changing, but when I feel that way, I know I need to get some exercise or I need to do, I can implement things.

In addition, the fact that women had a history of depression perhaps gives reason not only to why they may have developed PND, but also to why they are continuing to experience depressive symptoms, as suggested in the literature which has found a high relapse rate for depression (Gotlib et al., 1991; Philipps & O'Hara, 1991).

Women also described recovery from PND itself as achievable and they held on to the sense of hope that this was something that wasn't 'terminal' as discussed by Susan:

I mean as far as I'm concerned, yes I've recovered; I've come through the other side with medication, with support, with counselling; I've come through the depression. Do I still suffer from depression? God, yes. I slip back into that depressed stage very easily and I've got to be very, very careful; if I over stress

myself with work, I suffer from depression. I very quickly get into a depressed state again. Do I know how to manage it? Yes, I do, because I've got the skills now.

However, overall life experiences were perceived as something that would always affect women. This finding supports past research (Davidson & Roe, 2007) which describes an individual's capacity to achieve recovery in some aspects of their lives, but not in others as Emily said "I believe I've recovered from postnatal depression, but I haven't recovered from having a traumatic childhood, that's a trauma that's still there."

In addition, understanding and feeling comfortable with the role of motherhood appeared to be an important step for many women in recovering from PND. This supports the research undertaken by Maloney (1998) which discussed the resolution of role conflicts associated with motherhood to be important in reaching a level of recovery that she termed 'stable motherhood.'

Useful treatments

Women described a number of treatments that they had found useful in their recovery process. Interestingly, self-education was the most common strategy discussed, in the form of reading and researching PND to gain a greater understanding of what they were going through and why as Fiona said "So definitely self-education and it made me feel stronger, understanding more about it."

Knowledge of self was another important aspect in women's' recovery. As they became more aware of their triggers and limits they were able to reach a balance in life and were more able to manage their symptoms. Rachel discussed her experience in the following way:

I initially used cognitive behaviour therapy...so that just taught me just some really basic strategies about how to get on top of it when I was feeling at my lowest and I guess trying to find a balance in my everyday routine, between the family's needs and my own needs.

All of the participants' described utilising professional therapy during their PND experience(s). Therapy was mostly individual rather than group based and was found to be useful by most women, a finding which supports the literature that professionally administered therapy such as CBT and IPT are efficacious in the treatment of PND (Kopelman & Stuart, 2005). However, many women were also taking anti-depressant medication so it is difficult to assess the real effect of the therapy.

Peer support was utilised by half of the participants in their PND recovery. Those that did attend a support group found it very useful, except one woman who

attended for a short time and decided that the group was not where she needed to be at that time. Kathy described her experience of attending the support group as positive:

It was the first time in months that I felt as though there were people in the room who understood.

Women who did not utilise the support group did access the peer support helpline and recalled finding it reassuring to speak to a volunteer over the phone, as Donna stated, “I remember a particularly bad time I was having and I rang the helpline and it was just so good to have the supportive person understanding.” Women did not use peer support in their recovery because they were receiving professional help, or were unaware that the support group existed.

Antidepressant medication was used by several women who described it as “life saving”. Contrary to the evidence provided by Pearlstein (2006) that women were concerned with the effects medication might have on the breastfeeding infant, evidence was provided in this study that it was a useful tool, as Emily stated:

The Psychologist that I saw at the time, never acknowledged that depression was an illness and never encouraged that there was other ways I could help myself in the form of medication and it became so bad that I needed the medication to simply survive and when that started to work, I could slowly actually learn new coping skills.

Barriers to recovery

Professional therapy was not a useful treatment for two women, who found the therapy experience difficult; one woman described a scenario where she felt unsupported by the therapist who took leave and left her in the care of another professional, as she was beginning to open up and talk about some very difficult issues. Another participant “fought” the therapy because she had unresolved anger and was not necessarily able to express this effectively with the therapist.

Some women expressed having negative experiences with health professionals including psychologists, general practitioners, obstetricians and nursing staff that either contributed to their difficult transition to parenting, or made it difficult to attempt treatment. Susan recounted her second attempt at seeking help with a counsellor:

...anyway went to go and see another counsellor and I had about three sessions with her and I didn’t find her effective either, so I decided counselling wasn’t going to help me, I had to do it on my own.

Although on the whole women did find therapy useful, the finding that this process was sometimes difficult or that professionals did not live up to women’s

expectations, concurs with research attributing these experiences to the inception of the consumer movement (Frese & Davis, 1997; Norcross, 2000). In general women discussed difficulty with health professionals other than therapists involved in the perinatal period, who they perceived as being dismissive, uncaring and unsupportive in nature.

Motivational factors

Research has described volunteerism in consumer groups as a transition from consumer to carer (Anthony & Ashcraft, 2006), where individuals who once used a service become actively involved in the organisation and activities of that service. Contrary to these findings, this study has found that for some women, motivation for the decision to become a volunteer facilitator was more around their experiences of having PND and continuing to journey through a process of recovery rather than a direct progression from consumer to provider of the peer support service.

Empathy

Overwhelmingly, women did not want other women to go through what they had been through without support. Women were motivated to use their own experience to help other women toward recovery as Emily said, "I wanted to tell the whole world that PND is real and you don't have to suffer so much if you get the right help."

Those who had used peer support in their own recovery indicated that a motivational factor for them was the need to give something back because they had felt so supported by the support group as Kathy said, "I thought, I need to give something back because I feel so supported and nurtured and you have to, I think; you have to provide that so that the women feel, I've come through this in some way and I need to give something back." Others indicated that although they had not used peer support themselves, they believed they would have found it useful and this was what motivated them to be there for other women. Rachel described her thoughts in this way:

I think that if I had gone to the support group myself, just to be able to develop a relationship with two women (facilitators) who you can see have come out the other side and I think that probably if you are connecting with one or both of those women, then I think that is quite powerful.

Fiona's motivation to volunteer was similar:

In hindsight I found out the services were there, but at the time there was just seemingly no support, so I was all for wanting to help other mum's sort of get through it.

Personal benefits

In support of past research (Wilson & Musick, 1997; Wilson, 2000), women described many personal benefits associated with facilitating the support group. These benefits were factors that occurred from facilitation, but were not necessarily related to why women volunteered. However, it may be that these benefits gave women reason to continue facilitating over lengthy periods. Women indicated that facilitating the group contained an element of support for them and was a part of their own healing process. Women sometimes felt removed from the experience through listening to the stories of women in the group and they felt that feeling distanced from the experience was therapeutic in itself. Kathy said:

I should have kept doing the facilitating because it really, you know, it helped me and it helped; it wasn't entirely only helping people receiving the support; it wasn't entirely altruistic. I realised I was getting support in my own way, that's the wonderful thing about support, it becomes a two-way street.

Women described volunteering in this capacity as something positive that they could do with their feelings and with an experience that was inherently negative. Again, Kathy described her feelings regarding this:

I think for me it also helped the healing process because I felt as though I could do something with these feelings. I was so horrified by the whole experience; I was horrified by my reaction to birthing and motherhood and how strange I must be to have all these feelings; that I guess to be around other people who are feeling the same way...

Participants also commented on increased self-esteem, learning about oneself and about PND in general as benefits and ways in which their own recovery was strengthened.

This finding also relates to women's expression of self-education as an effective treatment tool. Emily stated:

After a while I realised that when you reach out to someone and you can be of a positive influence and that I suppose boosted my self esteem enormously...I also realised that um, I wasn't alone.

Women also agreed that facilitating had made them more compassionate, gave them a better understanding of other people's life situations and made them less judgemental. They also experienced a sense of satisfaction and personal fulfilment from seeing other women begin to recover and to "get their life back together." These benefits support previous literature (Downie, et al., 2005) which cites self-esteem and personal development as possible outcomes of the volunteer experience.

Also in support of previous literature, career benefits were afforded several women who obtained paid positions in counselling and women's mental health programs or those who decided to take on study in the area to secure future employment (Greenslade & White, 2005). There were several participants who indicated that facilitating the support group was good experience for them as they were anticipating a career in the field. However, although professional experience or career enhancement was a motivational factor for these women, it was not the sole factor in their decision. The experience of PND and the empathy for other women seemed to outweigh, or at least work in conjunction with, women's desire to use the facilitator role for career enhancement, as Donna said:

"I wanted something practical, hands on that I could actually do...I was really driven to be present and do it...I wanted to get some practice in groups as well...but it was mostly, I just remember the overriding feeling was that I didn't want other women to go through what I'd gone through."

In fact, this is an interesting finding in relation to how peer support groups recruit their volunteers. Although it is accepted that in use of the peer support model, facilitators must have experienced PND themselves, it may be useful to consider how women's existing counselling skills or desire to pursue such a career might be utilised in recruitment and retention.

Challenges of facilitating

The theme regarding challenges of facilitating appeared important to discuss in relation to women's facilitating experience and how their decision to remain in the role or to move on, was initiated.

Empathetic exhaustion

It was discussed that sometimes stories told within the support group are confronting and may touch a nerve with facilitators. Women described it as hard to listen to some of the women's experiences within the group, particularly if they were more extreme or contained more challenging issues than the facilitators own, as Fiona said, "I'm hearing all these stories about really awful things that are going on behind closed doors; it was really tragic." Alternatively, some stories reminded facilitators of their own experiences and while most were able to leave it behind in the group and not let it affect them in their daily living, one woman described feeling "empathetically exhausted" following the group. Linda said, "sometimes I experience a day of feeling a bit melancholic a couple of days afterwards and then I look back and I think, ok, you've

been expending quite a bit of energy in the facilitation of the group.” Linda also described her facilitating experience in this way:

...women who are suicidal and women who can't see any way through it and are finding life pretty unbearable...trying to get women beyond seeing a support group and into actually seeking mental health professionals...women who've had negative experience with mental health professionals and are really wanting to avoid having to go down that path. Trying to get them out of the support group and on to other services requires a lot of energy.

In addition to being an issue with the way that facilitating can make women feel, these statements also highlight the management issues women face in their own recovery whilst in the facilitator role.

Women also described feeling discouraged at not being able to solve women's issues for them and described this as not being able to do enough. Emily was able to resolve this conflict as she said:

...the challenge was, to see people really suffer and feeling unable to help them...that was heartbreaking. That really took a lot of soul searching for me to understand that even though I can't fix somebody's life, I can still be of some benefit, of some support.

In removing themselves from the role of facilitator, women described a loss of empathy as an important factor in their decision. Fiona described her decision to cease facilitating in this way:

There's a point where you are sitting in a support group and you lose a little bit of that empathy, you lose that 'I'm with you' kind of feeling...it's draining; it's really, really draining.

This experience may be related to what is commonly referred to in the human services as burnout, which is characterised by emotional exhaustion (Bakker et al., 2006), and subsequent withdrawal of participation by volunteers.

Emily also cited loss of empathy as a major factor in turning away from facilitation:

The biggest factor for me in moving away from facilitating was that as my kids got older, I found that...they have sort of different issues and I found it harder to relate to women with really small babies...so I felt that my empathy was sort of dwindling and I really believed these women deserve an empathic supporter.

It may also be that the loss of empathy is a sign of continued healing and recovery, a role change or life cycle transition as discussed by Rotolo (2000) and is the

point where some women are able to move on from being in that supportive role, as described by Donna:

I think you work where you need to heal; part of knowing I'm getting healthier is I'm finding less need to be in that area...I don't need it to consume everything. This finding might also relate to the 'group-identity model' described by Thoits and Hewitt (2001) in which volunteerism is both initiated and sustained by an individual's motivation to help those who they identify with. It appears that some women could no longer identify with the women in the group and therefore their volunteering was not sustained.

A current facilitator expressed her thoughts on why she intended to remain a facilitator which also relates to the impact of the PND experience, the recovery process and how it is intertwined with the facilitator role:

I'd like to keep going as long as I can. I think too that women get back on with their lives, this is a phase in their lives; whereas for me, I think this was life changing and this has given me a renewed sense of purpose; and I think what interests me too is...what it is in our culture, that is missing in the support network.

Discussion

In general, PND was experienced as a major life episode for women that had a significant impact on their lives. The development of PND symptoms was primarily attributed to past history of depression, feelings of isolation, unpreparedness and societal pressure to be the "perfect" mother. Due to these factors, women were driven to seek out peers or professionals who were understanding of their PND issues, to aid in their recovery.

The recovery process was ongoing for most women. Women saw their PND as something that could be overcome, but were prepared that they may continue to experience "melancholic moods" and may experience another major episode in the future. This finding supports the 'recovery in' theory described by Davidson and Roe (2007) and gives further insight into how women experience this phenomenon. Women used both peer support and professional therapy in their recovery, however peer support was particularly useful in reducing feelings of isolation and in "normalising" the experience.

The way in which women experienced PND and the recovery journey, as described above, give a basis for why women made a decision to become a support group facilitator. In addition, women were motivated by feelings of empathy towards

other women. This motivational factor appeared to outweigh other factors such as personal benefit in the form of career advancement. Those who had used peer support in their own recovery described feeling supported and nurtured by that experience and hence felt a need to “give back”. However, the transition from consumer to carer was not a main theme in women’s stories, moreover, the experience of PND and recovery process appeared more influential in their decision. Women also described the facilitator role as therapeutic as they began to feel removed from the PND experience, as well as finding mutual supportiveness through being involved in the group process.

Challenges associated with the facilitator role appeared to effect women’s length of service. In particular, women described feeling “empathetically exhausted” following facilitation of a group. This phenomenon appears to be a form of burnout which women experience due to the sometimes intense nature of the group situation. In addition, women appeared to be journeying through their own recovery and therefore, may be more susceptible to feelings associated with burnout. Women also experienced a loss of empathy with the women in the groups, another documented symptom of burnout. However, it appears that in some cases the loss of empathy may be a positive reflection on the facilitators own state of recovery. This finding may also support Rotolo’s (2000) theory regarding the influence of an individual’s life cycle position on volunteering behaviour.

Conclusions

Limitations

A 47% response rate was achieved from the mail out of information regarding the study. Limited and perhaps outdated records available for use in this mail out contributed to a lower number of respondents than would have been ideal. A larger sample of women may have further consolidated the themes presented here, or perhaps provided new themes that would have been important to the area of research.

The mixture of past and present facilitators was an issue with the design of the study. It may have been preferable to interview current facilitators only, however due to the limited nature of the PNDSA’s volunteer levels at the time, past facilitators were also contacted. The accounts given by past facilitators may have been useful, giving insight into why volunteers chose to leave the facilitator role.

Replication of the study may not be possible due to its qualitative and contextual nature and the findings are not necessarily able to be generalised to other populations or situations.

Implications

This study has given an insight into how women involved in a peer support group came upon a decision to volunteer as a facilitator. The main motivational factor for women in this sample appeared to be empathy for others derived from their own experience of PND and the recovery process.

Women's own participation in a peer support group was not necessarily a factor in their decision to facilitate, as only half of the participants actually attended a support group in their own recovery process.

Findings related to women's experience of recovery support past research by Davidson and Roe (2007) which describes "recovery in" rather than recovery from, mental illness. Women had come to a point in their recovery where they felt able to facilitate, however still experienced symptoms of depression. This finding has important implications for the literature regarding burnout in human services. The feelings of "empathetic exhaustion" described by women may impact on the ability to successfully support women in the group whilst continuing their own recovery. Implications also arise for the retention of volunteers in the facilitator role when symptoms of burnout are being experienced.

Finally, the loss of empathy described by women may be an important enigma. It is unclear as to whether this phenomena is a symptom of burnout or a more positive sign that the facilitator is continuing on their recovery journey to a point where they can remove themselves from the need to support others.

Future directions

Further research may need to include peer support programs other than the PNDSA to ensure a larger number of participants. This may also offer the possibility of only interviewing women who are currently in the facilitating role, to gain a better perspective on their experiences.

Future qualitative studies may also benefit from longer interview times to allow further questioning and the gathering of more in-depth information. Further research into volunteerism in this field and others is important, particularly for agencies to gain further understanding of who volunteers and how best to recruit these people.

A focus for future studies might include what structures peer support organisations can put in place to assist volunteers to remain involved, regardless of their own stage in the recovery process. Further research may attempt to describe and clarify the loss of empathy experienced by women as either a symptom of burnout which has

implications for retention of volunteers, or as another step in the recovery process for women.

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Appendix A
Information Letter to Participants

Dear Facilitator,

My name is Tracey Parker and I am currently studying Psychology at Edith Cowan University. As part of my course requirement for Honours, I am required to undertake a research project in an area where there is a need to expand the existing body of psychological literature.

I have decided to explore the topic of postnatal depression (PND) and why women who have recovered from PND might volunteer in a supportive role. The main aim of the project is to find out what your experience of becoming a parent was like, how you came to be a group facilitator and what issues were important to the experience that you describe. To participate in this study you will need to be or have been a support group facilitator with the PNDSA. This project has been approved by the Edith Cowan University Human Research Ethics Committee.

If you agree to participate in this study, you will be invited to attend a 45 minute face to face audiotape recorded interview, with myself at Edith Cowan University, Joondalup, your local public library or in another location of your choice. Although there are some questions that I would like to ask, the format of the interview will be a conversational style so that I can gain an insight into your experience. Following the interview you will be offered contact details for further debriefing should you feel it necessary.

Any information that identifies you will be omitted from the finished project. Before taking part in the interview you will be asked to sign a consent form, however you are free to withdraw your consent to participate at any time or refuse to answer any question. Following the transcription of the taped interview, the tape will be erased. Some participants will be offered the opportunity to provide comments regarding the interview and to provide feedback on my interpretations, at a later date. You will have the opportunity to view the finished project in May 2009.

If you would like to participate in this project, or discuss any aspect of it, please do not hesitate to contact me on 0407447108. If you wish to speak to someone else connected to the study you may contact my supervisor, Dr Elizabeth Kaczmarek on 6304 5193. Alternatively, if you wish to speak with someone not connected to the study, please contact Kim Gifkins, Research Ethics Officer on 6304 2170.

Thank you for taking the time to read the information above and for your participation in the project.

Tracey Parker

Please keep this information sheet for your reference

Appendix B
Participant Consent Form

Project Title: An exploration of the experiences leading to volunteer facilitation of postnatal depression peer support groups.

Please read the following statements and sign below if you agree to participate.

I _____ (the participant) have read the information sheet provided and any questions I have asked have been answered to my satisfaction.

I agree to participate in the activities associated with this research and understand that I can withdraw my consent at any time or refuse to answer any question put to me without reason.

I agree to be audiotape recorded during the interview and understand that the tape will be erased following transcription of the interview.

I do/do not wish to be contacted at a later date to provide comments regarding the interview and feedback on the researcher's interpretations.

I understand that any identifying information will be erased from the finished work; that I have the right to view the finished project; and that the study may be published.

Participant's Signature _____ **Date** _____

Participant's First Name _____

Contact Number _____

Researcher's Signature _____

Appendix C
Participant Demographic Form

Given name _____ **Surname** _____

Date of birth/Age _____ **Contact number** _____

Suburb _____

Number of children and ages _____

Length of time as volunteer for PNDSA _____

Support received in PND recovery i.e. therapy/self-help _____

Appendix D Interview Schedule

1. Can you tell me about your postnatal depression?

Prompt: What factors do you feel contributed to it?

Prompt: What helped you overcome it?

2. Can you tell me about your experience of working as a PND group facilitator?

Prompt: What led you to become a facilitator?

Prompt: What are some of the benefits and challenges that you have had while facilitating?

Prompt: How long do you wish to remain a facilitator?
(current facilitators)
What prompted you to cease facilitating?
(past facilitators)

Appendix E
Question-ordered Matrix
(Example only)

Participants	What factors do you feel contributed to it?	What helped you overcome it?	What led you to become a facilitator?	Benefits?	Challenges?	Decision to leave/remain?
Rachel	Personal history, family history, isolation	Therapy, medication, self-education, continued medication for depression, exercise	Give something back as having the exp, empathy	Removed from experience	Confronting stories	Wishes to remain reasonably long term, perhaps be involved in other ways
Jenny	Personal history, family history, isolation, perfectionist	Didn't find therapy or support helpful, continues to suffer depression	Wanted to support other women, empathy	More compassion, understanding, less judgemental	Some stories still "touch nerve"	One day at a time
Donna	Personal history, family history, rel. With mother, financial	Separation from partner, therapy, volunteering with PND SA, self-education, ongoing depressive eps.	Professional group work experience, didn't want others to go through it alone, empathy	Career benefits	Some stuff still "hit nerves"	Financial/work needs. Less urgency to work in area
Emily	Unprepared, lack of info, family history, personal history, rel. with mother	Psychiatrist, medication, psychologist, coping and self care skills, ongoing depression	Commitment to make change and help others, empathy	Learnt about self, self-esteem boosted, didn't know support existed own PND	Not being able to do enough, loss of empathy	Own children grew older, felt removed from experience, unable to relate
Fiona	Personal history, isolation, unprepared.	Therapy, support group, self-education, ongoing depression	Got little support in own experience- wanted to help others, empathy	Self-education, understanding more made her stronger, seeing others benefit	Complex issues and confronting stories.	Loss of empathy, draining, pursue other interests
Kathy	Family history, rel. with own mother	Support group, self-education, medication, supportive partner	Give something back because she had felt so supported, empathy	Career path, support for self	Getting women to move on	Left to pursue counselling employment
Linda	Unprepared, overwhelmed, unsupportive partner	Support group, therapy, self-education, exercise, ongoing dep.	Give something back, career, distance self from PND, empathy	More empathy, seeing women recover, puts things in perspective.	Empathetically exhausting, suicidal women.	Continue, own benefit and others, PND exp was life changing.

Appendix F

Summary Statements and Quotes (Example only)

Motivational factors

Empathy

The most prominent motivational factor for women to volunteer as a support group facilitator appeared to be the feeling of not wanting other women to go through what they had been through without support. Women felt that they could use their own experience to help other women to recover and were motivated by their own experiences of PND in relation to what support they received. Some women felt as though they had not received adequate support and did not want other women to experience this. Other women felt so supported by other women, that they wanted to be involved in giving something back.

Quotes:

1. "I was just like, no, there must be lots of women out there suffering like I was and I don't want that to happen."
2. "I wanted to tell the whole world that PND is real and you don't have to suffer so much if you get the right help."
3. "I looked around and I thought I needed to give something back because I feel so supported and nurtured."
4. "in hindsight I found out the services were there, but at the time there was just seemingly no support so I was all for wanting to help other mums' sort of get through it."
5. "It was a way that I could fulfil this needing to give something back, particularly to women who I thought were going through something that I understood."
6. "I felt therapeutically it would really help me as well to distance myself a bit further from the experience while helping other women to appreciate their own experience."
7. "I think that if I had gone to the support group myself, just to be able to develop a relationship with two women (facilitators) who you can see have come out the other side and I think that probably if you are connecting with one or both of those women then I think that is quite powerful."