A qualitative study of the experiences of a group of Hong Kong Chinese women diagnosed with postnatal depression

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Aim of the study. To examine the lived experiences of a group of Hong Kong Chinese women diagnosed with postnatal depression.

Background. Postnatal depression affects approximately 1 in 10 childbearing women in Hong Kong. However, most studies of postnatal depression have been carried out in Western societies and no qualitative research was found describing the experience of Hong Kong Chinese mothers with postnatal depression.

Design. A phenomenological study was conducted. Data were collected by semi-structured interviews. A purposive sample of 35 women diagnosed with postnatal depression was interviewed. Interview data were analysed following Colaizzi's phenomenological methodology.

Results. Themes that emerged describing participants' experiences included trapped in the situation, ambivalent towards the baby, uncaring husband, and controlling and powerful in-laws. Women felt hopelessness, helplessness and loss of control. They were trapped in a situation that had no way of escape except by violent means, such as homicide or suicide. Feelings towards the baby were ambivalent, both hate and love. Several women had injured, or had thought of injuring or killing, their babies and/or themselves. Women's unhappiness was attributed to a noncaring husband, and controlling and powerful in-laws. Generally, women did not seek help until their depression was diagnosed by screening tests.

Conclusion. This study has revealed insights into how women experienced postnatal depression in Hong Kong, and what they perceived as contributing to their depression. These insights may be used to guide interventions for women and their families to raise awareness regarding the support childbearing women need.

Keywords: postnatal depression, qualitative experience, Hong Kong Chinese women

Introduction

Postnatal depression (PND) refers to a non-psychotic depressive illness of moderate severity that can last for several weeks, months or even a year following childbirth (Cox 1989). The clinical picture is comparable to depression that is unrelated to childbirth, with the most common presenting symptoms being dysphoria, insomnia and fatigue (Creedy & Shochet 1996). Postnatal depression affects 10–20% of recently delivered Hong Kong Chinese women which is similar to Caucasian populations (Beck 1998, Lee *et al.* 1998). Most studies of PND have adopted a quantitative approach that focused on prevalence and estimation of risk factors. There are very few studies of the experience of PND from women's point of view (Beck 1992).

A literature review found that most of the studies of PND have been conducted in Western societies. Hong Kong is a place with combined Chinese and Western cultures. Its unique culture needs special consideration when health care professionals are providing care to Chinese mothers with PND. The Chinese experience and way of expressing depression should not be assumed to be the same as that experienced and expressed by other groups. This paper reports a study on the qualitative experience of a group of Hong Kong Chinese women who suffered from PND.

Literature review

Pregnancy and the postnatal period are often emotionally fraught. Childbirth could be the source of great happiness and excitement throughout the family. However, it may result directly in physiological upheavals, changes in relationships, altered body image, different daily routines and work patterns, and perhaps financial, housing and other crises (Levy 1991, Beck 1995, Sheehan 1981). In view of the intense physiological and social changes experienced by women during pregnancy it is not surprising that some women develop depression during pregnancy and the first postnatal year. In the United Kingdom (UK), PND affected approximately 10% of newly delivered women (Stein *et al.* 1989). The incidence of PND in the United States of America (USA) ranged from 8% to 26% (Beck 1998). PND is a destructive condition, rendering the mother apathetic and joyless. Marital breakdown and adverse effects on the children's cognitive and emotional functioning have been directly attributed to the effects of PND (Cogill *et al.* 1986, Beck 1998).

Much of the work on the prevalence and management of PND have been conducted in Western cultures. For example, Beck (1992) conducted a study on the lived experience of women with PND in the USA and 11 themes emerged from the data. Themes included loneliness, obsessive thinking, insecurities, anxiety attacks, loss of control, guilt, diminished concentration, fear that life would never be normal again, loss of interest in hobbies or goals, lack of all positive emotions, and contemplation of death. One-year later, Beck conducted another study using the grounded theory method and developed a substantive theory of PND. The theory stated that mothers suffering from PND attempted to cope with the problem of loss of control through the four-stage process which included encountering terror, dying of self, struggling to survive, and regaining control (Beck 1993). However, it is not known whether Chinese women with PND would have the same experience.

Traditionally, Chinese women received lots of attention from their family after giving birth. 'Zuo Yue' (doing the month), and 'Pei Yue' (attending the month) are the examples of Chinese cultural practices. In 'Zuo Yue', there are health practices that the new mother has to perform, such as staying at home during the first month after delivery and taking nutritious food, such as chicken wine and ginger vinegar, which are believed to be good for the new mother's recovery. In 'Pei Yue', the new mother is attended by a female relative, who looks after her and her baby during the first month after giving birth (Chen *et al.* 1994). These traditional practices and rituals give intimacy as well as enriched emotional and material support that strengthen a mother's self-esteem and provide a buffer against the stress and difficulty encountered in early motherhood. A study by Lee *et al.* (1998) suggested that these practices might protect women against depression in the first month after giving birth to a baby.

Because of the recent modernization and changes from an agricultural to industrial society in Hong Kong, there have been changes in family structure. There are now more nuclear than extended families. Women are expected to take care of their babies immediately after discharge from hospital (Huang & Mathers 2001). New mothers can no longer rely on their relatives to be with them in the weeks or months after childbirth (Barclay 1995). They have to turn to their husbands for support. If the needed support cannot be obtained, this might affect the mental health of the women.

Nurses play an important role in identifying and supporting depressed women. It is first necessary to explore the experiences of Hong Kong Chinese women with PND in order to suggest how nurses might use their skills to prevent, detect and help to minimize the effects of this depression. It is acknowledged that sociocultural factors influence health care beliefs and behaviours. Nurses need to have insight into these factors to deliver culturally sensitive nursing care.

The study

Purpose

To examine the lived experiences of a group of Hong Kong Chinese women diagnosed with postnatal depression.

Objectives

- To examine the experience of depression of Hong Kong Chinese women who are diagnosed as having major or minor degrees of PND;
- to investigate the factors perceived by the women as contributing to their depression; and
- to identify the help-seeking behaviours of the women.

Design

A phenomenological study was conducted. Phenomenology derives from the Greek word 'phenomenon', which means 'to show itself' (Ray 1994). It is a research approach that aims to describe and reveal human experience as it is consciously experienced, without preconceptions and prejudices (Husserl 1970, Beck 1992). Phenomenology asserts that reality is not a fixed entity, it changes and develops according to people's experiences, and the social context within which they find themselves. The implication is that the proper understanding of people's illness experience must include the person's subjective experience and understanding of the illness, and the social context within which that experience and understanding occur (Porter 1996).

To achieve an understanding of subjective human experience, the researcher has to set aside one's taken-for-granted orientation of the study subject. All ontological judgements about the nature and essence of the study subject are suspended. This process is called 'bracketing' (Holstein & Gubrium 1994), which is considered crucial to the success of phenomenological research (Beck 1992).

All the researchers involved in this study are experienced health care professionals and have past experience and knowledge on PND. It is easy to impose our presuppositions of PND onto the data. In this study, the research team set aside their personal preconceived ideas on PND and expectations regarding the participants' responses in order to interpret accurately the reality described by the participants. As directed by Ray (1994), data analysis was a reflective process and involved a sensitive attunement to opening up to the meaning of experience. The descriptions of meaning of the data were presuppositionless and guided by intuition.

An in-depth semi-structured interview was used to collect data. A member of the research team, who was an experienced Registered Psychiatric Nurse, conducted all the interviews. The interviews were carried out by one researcher only, and thereby high uniformity in the conduct of interviews was maintained, and errors produced by differences in interviewers were avoided. To eliminate errors in memory and avoid interference caused by note-taking during the interview, audio-recording of the interview was carried out.

Sample

A purposive sample of Hong Kong Chinese women who had been diagnosed by psychiatrists as experiencing major or minor PND, according to Diagnostic and Statistical Manual IV criteria (American Psychiatric Association 1994), was recruited from a PND clinic, which is situated at the outpatient department of the Obstetric Unit. The Edinburgh Postnatal Depression Scale (EPDS), which is a 10-item screening tool developed in 1987 (Cox 1989), is used in the Unit as a routine screening tool. Women who obtained a total score over 10 were referred to the PND clinic.

Participants in this study had not sought or obtained help until the EPDS revealed a possibility of depression and they were invited to attend the PND clinic. Verbal permission was sought from the participant by the psychiatrist before referring her to the research team. Participants were approached at the PND clinic by the researcher. Women who were willing to participate but who were unable, for whatever reason, usefully to articulate their experiences of depression were not included in the study.

Ethical considerations

Permission to conduct this study was sought from the Chief of Service and the Hospital Chief Executive of the study venue. The length of time since the participants were diagnosed of PND ranged from 6 to 12 months. No participant was in the acute phase of the depression. The purposes of the study, the process of the interview and purpose of audio recording were explained to the women and written consent was obtained before interview. Confidentiality was assured, the participant's name would not be associated with the report in any way, and she had the right to withdraw from the study at any time.

The researcher, who carried out all the interviews, was a psychiatric nurse and had received training in conducting interviews. The psychiatrist continued to treat the participants during the study period. During the course of interview, if the participant expressed thoughts or emotions that were of importance to her treatment, her permission to communicate this information to the psychiatrist was sought. However, if she communicated thoughts or plans that would cause

immediate harm to herself or others, the researcher, as a professional nurse, was obliged to communicate the information to the psychiatrist and to take immediate action to protect the participant and any potential victims.

This type of qualitative interviewing may release deeply felt emotions that require sensitive and compassionate handling by the interviewer (Levy 1991). The researcher possessed the necessary skills to assist and support a woman should she become distressed, and the back-up services of the psychiatric department were also available for further support should they be needed, and agreed to by participants.

Data collection

Brief demographic data were collected at the initial contact between the participant and researcher in the clinic. This initial contact also aimed at facilitating the expression of true feelings in the subsequent interview by building up rapport between the participant and interviewer. An appointment was then made with the participant for an interview.

Interviews were carried out at the PND clinic or at an alternative place that the participant preferred, for example, in a park or restaurant. In order to encourage freedom of expression, the interview was loosely structured, guided by a brief interview schedule comprising open-ended questions. Appendix 1 shows examples of the questions. The length of each interview was about an hour.

Data analysis

Demographic data were summarized by descriptive statistics. The computer programme 'Ethnograph' was used to assist with qualitative data analysis. Each transcript of the women's oral description of a PND experience was analysing following Colaizzi's (1978) phenomenological methodology:

1 All the subjects' oral descriptions were read in order to obtain a feel for them.
2 From each transcript significant statements and phrases that directly pertained to PND were extracted.
3 Meanings were formulated from these significant statements and phrases.
4 The formulated meanings were organized into clusters of themes.
5 The results of the data analysis so far were integrated into an exhaustive description of PND.
6 To achieve final validation, the researcher returned to the participants with the exhaustive description.

Two investigators in the research team were responsible for data analysis. They collaborated closely in cross-analysing in order to achieve consistency and agreement at each step of the data analysis to validate the findings.

As suggested by Lincoln and Guba (1985), member checks were performed to enhance the credibility of the findings. Three participants were selected randomly and they were asked to review the description of the findings to confirm that it accurately reflected the essence of their lived experiences with PND. All agreed that the themes generated from the data were accurate reflections of their experiences.

Findings

Demographic data

Thirty-five women were interviewed. This sample size, which was considered a large number for a phenomenological study (Morse 1994), was a requirement by the funding body. Participants' age ranged from 20 to 40 years, 88·6% ($n = 31$) of women had finished their secondary school education, and 97·1% were married. The majority had nuclear families. Only 8·5% of the women were unemployed outside their home. The majority had a household income between HK$ 11 000–30 000 (£ 1000–2727), and so were mostly middle class women.

The themes identified from the data describing participants' experience, feeling towards the baby, their in-laws and their husbands are described below.

Theme 1 – Trapped in the situation

Feeling of being trapped in the situation was the predominant theme that emerged from the data. The majority of participants felt trapped by their depression, which they could not escape. Feelings of hopelessness and helplessness were common. They could not find help from other sources and they perceived no hope in getting out of the situation.

One participant said: I could not see any light in the future. There is no one helping me. I lost hope at that time. Another said: I could not see any way out. I lost all my hope and confidence.

Participants frequently mentioned loss of control over their emotion and behaviour. One said: I suffered greatly. I could not control my emotion and behaviour. I have no idea of how to solve the problem. In the past, I was so full of confidence, but at that time I lost all my abilities to cope.

Many participants described how they were tired and confused. There were endless things to do and the baby cried all the time. They generally expressed poor self-esteem because they could not accomplish tasks that they used to be very competent in. They had guilty feelings that they were unable to take care of the baby.

Feelings of anxiety and fear were common. Women were anxious and fear that something dreadful would happen to the baby. 'Phantom crying' was a common experience in which they reported actually hearing their baby cry, but when they went to check the baby was sound asleep.

There was a great deal of anger expressed by the participants. They were angry about the way they were being treated by their husbands and in-laws. However, they had no ability to change the situation or escape. These feelings were particularly prominent at the early stages. Some could not see any way out except by violent means, that is, by suicide, infanticide or homicide of the person to whom they attributed their depression. One said that she had thought of poisoning her husband and mother-in-law, who treated her so badly.

In time, however, and often after counselling at the PND clinic, other means of escape became apparent. One said that she would seek a divorce from her uncaring and controlling husband. Another would like to regain control in some other way, such as returning to work. Attendance at the PND clinic certainly appeared effective for most women, who said they had been helped by talking to psychiatrists and nurses (mental health nurses and midwives) there. On the whole, women seemed to appreciate talking to a sympathetic listener, allowing them to unload their feelings.

However, some participants felt reluctant to attend the PND clinic, not believing they were depressed, or that anyone could help them. Several women did not take their prescribed medication because of the side-effects or because they felt they did not need it. Some were discouraged by their families from attending the clinic or taking medication.

Theme 2 – Ambivalent towards the baby

Feelings towards the baby were ambivalent, varying between love, indifference, dislike and hate. Some blamed the baby as a burden that caused this unhappiness. Some perceived the baby as the cause for the distancing from their husbands and for feeling useless. Six participants said they had actually, or had almost, purposely harmed the baby, for example, hitting the baby's legs when the baby would not stop crying, or pinching the baby. Others said they had been tempted to jump out of the window, taking the baby with them, particularly when feelings of anxiety overwhelmed them. Some reported feelings of love, pity and compassion towards their child, saying they had only stopped killing themselves because they knew their baby needed them and so for the baby's sake they kept on living.

Theme 3 – Uncaring husband

Relationships with husbands were cited as an important source of unhappiness by participants. Although some participants commented that their husbands were concerned about them, the majority described marital tension and a deterioration of the relationship during pregnancy or after the birth of the baby. One mentioned that her husband was getting more and more control over her after she resigned from her job to take care of the baby. She said:

> After giving birth to the baby, my husband had become more restrictive on my personal life. He did not allow me to go out of the flat.

> He set up a lot of rules for me to follow, I became very frustrated and angry. For example, when my friends wanted to visit me at home, my husband had certain 'visiting time' and all visits needed his approval.

Participants also felt that their husbands offered little help to them in relation to taking care of the baby and housework. Some felt that their husbands did not understand their feelings and could not offer them support. One said:

> He did not understand the hurt, hard feelings that I was experiencing. He only responded that it was not worth mentioning.

Although a small number of informants said that their husbands cared for them, husbands generally did not know how to express their feelings. One participant said:

> He cares for me and treasures me but he is a man, he likes to keep his emotions and feelings to himself.

Theme 4 – Controlling and powerful in-laws

Many participants attributed their unhappiness to the relationship with their parent-in-law, and often complained of having to endure the unkind comments and behaviour of their mother-in-law. For example, the mother-in-law of one woman lived in the same flat, and would play Mah-Jong until early morning and the noise of this kept the woman awake when she felt in desperate need of sleep. She felt unable to ask her mother-in-law to make less noise, and neither would her husband.

Participants felt that their husbands were on the side of their mother. Although they experienced unhappiness with the mother-in-laws, they could not obtain support from their husbands. One said:

> I talked to him about how his mother treated me. Sometimes he agreed, but he would comment that I was too sensitive. Therefore, I gave up talking to him.

Many participants' unhappiness was related to their perception that their parents-in-law were authoritative and dominant. One mentioned:

> My father-in-law chose a name for the baby, which we (participant and her husband) considered as an awful name. Neither of us liked the name and we asked if there was a second choice. He said 'No, this was the best name and we had to use it'. My mother-in-law and sister-in-law gave us pressure, asked us to follow my father-in-law's wishes. I was very unhappy about it.

The gender of the baby was another issue affecting the relationship between participants and in-laws, and women were under pressure to give birth to a boy. Although the majority of participants accepted both boys and girls, the senior members of the family preferred boys. One participant described how the father-in-law did not like the baby girl. She said:

> My father-in-law did not cuddle the baby. He said he did not want to hurt the baby as she was too small. My impression was because the baby was not a boy, he was reluctant to get close to her. I was very angry with him and very unhappy about it.

Discussion

The feeling of entrapment was the central theme that emerged from the data. The woman was anxious, confused, tired, sad, worried and angry. She lost control of herself and perceived no hope in the future. The only way of escape that she perceived was by using violent means such as by suicide or homicide. The burden of caring for the baby, the uncaring husband and the controlling and powerful in-laws were factors contributing to depression. In time, often after counselling, other nonviolent means of escape became apparent, such as a divorce or getting a job.

Childbirth is an experience that brings many changes and women need support to cope with these changes. Perceived lack of support from husbands and families might contribute to PND. Furthermore, services for women with PND in Hong Kong are not well-developed (Cheng *et al.* 1994), and women might not be able to find help from external sources. This perceived lack of internal and external support might heighten this feeling of entrapment. Whitton (1996) agrees that people become depressed when they perceive themselves as powerless to control a stressful situation, and our study supports this assertion.

Although the family is an important source of social support to individuals in Chinese society, it can also be a burden and source of unhappiness, and is thus a double-edged sword (Kuo & Kavanagh 1994). It is possible that the presence of a family member can induce stress to a new mother, as in this study, where relationships between participants and in-laws were perceived as the major cause of unhappiness.

The literature maintains that the dominant position of the mother-in-law has its root in Chinese Confucian societies (Slote & Devos 1998) who suggest that, although all Chinese societies were male dominant, within the home it was the mother who was the primary force. It was she who ran the household and brought up the children. The primary emotional tie was between mother and son, not husband and wife. Mothers usually turned to the children, especially sons for the comfort and devotion that they did not find in the husbands. The relationship between mother and son is thus firmly entrenched. The daughter-in-law is regarded as a stranger in the house who takes away the son's love from the mother. Slote and DeVos maintain that in families where the attachment of son to mother is strong, daughter-in-law and mother-in-law conflicts are common. These conflicts are not unique to Hong Kong, but are also reported in other Confucian societies.

We found that the husband's family appeared to be very powerful and controlling, and participants had difficulties in doing things against the family's wishes. Bond (1996) reports that the value of filial piety is still strongly held among Hong Kong Chinese. The obligation of respect and obedience to senior members of the family remains a traditional value strongly adhered to in Hong Kong. This is influenced by Chinese traditions of emphasis on harmony, interdependence and loyalty, which are different from Western ideals of competitiveness, independence and change (Kuo & Kavanagh 1994).

The majority of the women in this study had received average education and many had a job. They were financially independent. Influenced by the Western culture that assertiveness is being valued and encouraged, participants might nevertheless found it difficult in reality to be assertive and outspoken. Although Hong Kong women may appear 'Westernised' on the surface, they still feel an obligation to obey the senior family members and they perceive powerlessness to fight back.

The gender of the baby appeared to be a cause of stress for the mother. In the traditional Chinese family system, sons are accorded special status. They continue the family name and conduct the rituals of ancestor worship (Slote & Devos 1998). The value of son preference seems to have been weakened as a result of the success of the family planning programme in many Asian countries. Yet, although most participants had no preference about the gender of the baby, the preference for a son to carry the family name still continues in older generations.

Problems of dissonance between Chinese and Western culture might have particular impact on adults of the age range 20–40, like the participants in this study. They have mostly been brought up in Hong Kong and received a Western education, whereas their parents came from Mainland China and are considered as very traditional Chinese. The differences in value and belief systems between the two generations may manifest explicitly around childbirth, such as the preference for a male baby or the naming of the baby.

Harmonious, interdependent interpersonal and family relationships are strongly encouraged and emphasized in Chinese society, which are regarded as a way towards happiness, a peaceful mind and psychosocial equilibrium (Lin *et al.* 1995). Our participants were in a dilemma. On the one hand, they tried to maintain harmonious relationships in the family, but on the other, they were unhappy because they had to sacrifice themselves. Kuo and Kavanagh (1994) suggested that depression is usually associated with poor interpersonal relationships in Chinese society. Such relationships between participants and in-laws, which might contribute to PND and as found in our study, has not been reported previously in the literature.

The majority of participants in this study perceived their husbands as uncaring and controlling. In Hong Kong, traditional gender roles continue to prevail in the family, the man is the breadwinner and the woman the caregiver, even if both spouses are employed. Men are the decision-makers and women the home-makers (Westwood *et al.* 1995). The dominant position of the husband might make it difficult for the wife to ask for help. Past studies have generally illustrated that the perceived lack of support from the husband and poor marital relationship is associated with a high risk of PND (Gottlieb 1983, Ballard *et al.* 1994, Beck 1996, Marks *et al.* 1996, Misri *et al.* 2000). The present study also suggested this association.

The findings of this study shared some similarities with those found of Western studies (Beck 1992) in which feelings of helplessness and hopelessness, loss of control, ideas of infanticide and self-destruction were common. However, ambivalent feelings toward the baby, which was a common finding in this study, have not been mentioned in other PND studies, such as those of Beck (1992) and Littlewood and McHugh (1997), and have also not been mentioned in Chinese literature. Bowlby (1979) used a psychoanalytic approach to explain this phenomenon. He suggested that the intense emotion that the mother felt towards the baby might evoke an intense need to possess the baby's love. However, the baby might not be able to return the love to the mother, for example, the baby is crying all the time and is very demanding. The mother might perceive a rejection from the baby and her love for the baby turns into resentment and hatred.

'Phantom crying' was a common phenomenon described by the participants, which has not been reported in previous literature. This phenomenon differs from the common anxiety in new parents where, for example, they may get out of bed several times during the night to check on the baby. In our study, the mother believed she actually heard the baby crying. It may be that her intense anxiety towards the baby generated the auditory hallucination. Bowlby (1979) suggested that a mother's intense anxiety towards the baby might be related to the recurrence of old feelings, such as the mother's intense ambivalence towards her own parents. The mother constantly worries that her baby may die and is unaware of the impulse in herself to kill the baby, adopting the same solution she adopted in childhood in regard her death-wishes against her own parents. We have made no attempt to prove or disapprove Freud's theory; however, this ambivalent feeling and the experience of 'phantom crying' is worthy of further study as the women who have experienced it have often found it disturbing; both mentally and physically.

Access to supporting network or resources outside the family is not common among Chinese women in Hong Kong (Westwood *et al.* 1995), and a service for women with PND is new in health care. The venue of this study is situated at the Obstetric Unit to lessen the stigma of relating it to psychiatry. However, many women were still unwilling to attend the clinic. In Chinese culture, self-discipline is regarded as the mainstay of social identity and behaviour, and self-esteem results from the knowledge that one is fulfilling one's social role with grace and dignity, and meeting expectations (Kuo & Kavenagh 1994). A woman experiencing PND might perceive failure in meeting the role of motherhood and consequent loss of face, and shame. Littlewood and McHugh (1997) argue that women and their families might not wish to be identified as not coping with motherhood and being perceived as inadequate. They might also worry that they would be labelled as mentally ill, and therefore unfit to be mothers.

From historical studies, it was noted that clients with mental health problems were treated in a humanistic way in ancient China. Mental health problems are seen as having a predominantly physical origin which are related to functions of organs such as the heart, lung, liver, spleen and kidney in Traditional Chinese Medicine (Chung & Chau 1997). However, since the 18th century, the practice of medicine in Hong Kong has been progressively influenced by Western medical model. Mental disorders are also related to stigma and superstitions. Families would feel ashamed, with a tendency to hide the family member with mental problem

at home until such time as care became an impossible burden, resulting in treatment being seriously delayed. Women's and families' attitudes towards mental health problems and a lack of knowledge about PND may have contributed to families discouraging women to attend the PND clinic or take the prescribed medication.

Previous studies on depression in Chinese culture have suggested that Chinese clients have difficulties in expressing their emotions and that somatization is common (Cheng 1993, Kuo & Kavanagh 1994). However, we found that participants were very capable of talking about their emotions and somatization was not detected. Pearson (1999) criticized that literature related to mental health in Chinese culture for tending to assume that the Chinese are a homogeneous group. Problems emerge with these crude generalizations as Hong Kong Chinese women may have different presentations of PND when compared with America Chinese, for example. Nurses need to take into account the socio-cultural aspects of their clients in providing care.

Implications of the study

It appears that services for supporting women with PND need to be developed. Health care professionals (especially nurses) could offer information and psychological support to women through hotlines or face-to-face individual counselling. If women are unwilling to come to the clinic, an outreach service can be established. Health care professionals can visit the women in their own homes to gain a better understanding of their life situation.

Support groups or self-help groups would be useful to mothers, and enable them to offer support and share experience with each other so that they can learn how to deal with their emotions and ways to cope with their roles as new mothers. Midwives and nurses working in the PND clinic or postnatal outpatient clinic could facilitate clients setting up these groups. Groups could also be organized for husbands. Our study showed that some husbands were willing to help; however, they did not know how to help or show their concerns. Husbands could learn how to help their wives through experience sharing and discussion in groups.

Education about PND is important for women and their families, and could enable early recognition and help-seeking. Education programmes on PND could be conducted antenatally as well as at postnatal clinics. These programmes could help family members to understand the stresses related to new motherhood and ways to help the women to cope with those stresses.

One of the limitations of this study is that family members were not interviewed. Future studies should consider the perceptions of husbands and family members towards PND.

Conclusion

Thirty-five Hong Kong Chinese women diagnosed with PND revealed that they were trapped in a situation in which they perceived loss of control over their lives, there was no help available and no hope in getting out of the situation. Feelings of anxiety and fear were common. Women's feelings towards their babies varied between love, indifference, dislike and hatred. Many related their depression to conflicts with the parents in law, which caused considerable distress. Poor relationships with husbands were revealed. This qualitative study has given insights into the experience of women with PND in Hong Kong, and these insights can be used to plan interventions for prevention, recognition and management of PND.

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Appendix 1 Interview guide

Please tell me about your pregnancy.
Please would you tell me how you have been feeling over the past few weeks/months after the birth of your baby.
Please describe a time when you felt particularly depressed. Please share all the thoughts, perceptions and feelings you can recall
What do you think made you feel like that?
Who would you go to for help? Please tell me about him/her
How do you feel about the diagnosis, what do you think the future holds for you?
So what do you make of all this?