Original Article

Journal of Wellness and Health Care Vol. 41 (2)
9 ～ 22 2017

Psychosocial process in mothers with depressed mood who continue to fulfill their parenting responsibilities

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Abstract

Objectives: To explore the psychosocial process in mothers that continue to fulfill their parenting responsibilities despite a depressed mood.

Methods: Semi-structured interviews were performed with 11 mothers with suspected depression based on Edinburgh Postnatal Depression Scale (≥ 9) or with strong anxiety about parenting that was detected at the 1-month postpartum examination or the 2 – 4-month newborn house visit. The grounded theory approach was used for the analysis.

Results: The mothers found <difficulties in parenting>, and ultimately reached a state of either <awareness of own inability> or <confidence in one's own parenting> through various routes. For example, depressed mothers, without help from their own mother and/or husband, felt lonely and isolated in <solo parenting>. Gaining «awareness of the current situation» was a decisive point. Those that gained awareness of their own effort became able to have a <change of mood> and <confidence in one's own parenting>, while those that did not gain awareness of their own effort underwent <parenting with a sense of resignation>, leading to <awareness of own inability>. Upon encounters with difficult <sudden incidents> during parenting, the lack of <connection to social support> immediately led depressed mothers to <awareness of own inability>.

Discussion: Mothers with depressed mood, without support, have limited capability to continue fulfilling their parenting responsibilities. The results of this study suggest that depressed mothers require support to prevent exhaustion from their own mothers, psychological support from their husbands, and support to reduce the sense of loneliness and isolation from their social networks.

KEY WORDS

Postpartum depression, Parenting, Grounded Theory Approach, Anxiety

Introduction

Postpartum mental illnesses are classified into six classes[1] : maternity blues; postpartum depression; puerperal psychosis; recurrence or relapse of underlying mental illness; organic mental disorders (e.g. Sheehan's syndrome) ; and mother–infant relationship disorders. Postpartum depression is defined as depression starting during pregnancy or within four weeks postpartum[2] . Kumar[3] reported that as many as 10–30% of perinatal women in Western Europe and North America have depression, while O'Hara et al.[4] reported this figure at 13%. Okano et al.[5] showed that the prevalence of postpartum depression in Japan within six months of birth was 9.6%. Suzumiya et al.[6] employed the Edinburgh Postnatal Depression Scale (EPDS)[7], and showed that 13.9% of mothers within four months postpartum had an EPDS score ≥ 9. It is apparent that a considerable proportion of mothers experience postpartum depression.

However, only a small proportion of perinatal women voluntarily visit specialized medical institutions for suspected depression[8] , even when advice to seek medical attention is provided as a result of EPDS-based screening[9–11]. This suggests that depressed mothers continue looking after their children despite their

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suspected postpartum depression without receiving specific care. It is therefore crucial to provide nursing care to those mothers. Specifically, a comprehensive interpretation of complicated psychosocial state of mind in mothers is essential to provide effective nursing care. Against this background, we conducted broad literature searches within the last five years to examine the state of research regarding mothers with postpartum depression or depressed mood.

There were three articles on feelings while parenting in mothers with postpartum depression, with emphasis on support from husbands, experience at health checkups, or parenting self-efficacy. Beck has focused on mothers with postpartum depression. Three studies reported findings of interviews of mothers who were on the treatment or had experience of receiving treatment for clinical postpartum depression, or more precisely, on their experience in parenting[12], on management of their depressive status[13], and on their experience in interacting with their children[14]. However, the focus of these three studies remained centered on the depressed status in mothers. We found one study about depressed mothers' infant-care experience during a one-month postpartum period[15], and one study about symptom-associated factors and aggravation in mothers who had had postpartum depression or anxieties within five years[16]: both demonstrated daily activities/events in mothers, but not parenting processes.

In Japan, we found four investigated the parenting experience of mothers. Shin et al.[17] and Matsubara et al.[18] employed a questionnaire to examine feelings of difficulties in parenting with their associating factors and the presence/absence of support in parenting, respectively. Tokuhiro et al. also used a questionnaire to study the proportion of mothers with feelings of denial and associated factors[19]. Fujino et al. conducted a qualitative study on parenting experience in 10 mothers who presented with a tendency towards depression (EPDS score ≥ 9) within one month postpartum[9]. Briefly, semi-structured interviews revealed that these mothers experienced "feelings of loss of efficacy in parenting", tended not to ask for help, and were isolated and trapped in parenting as support from their own mothers and husbands was not available.

Taken together, we detected no studies depicting the psychology of mothers with depressed mood who continue fulfilling their responsibilities. Further study is needed to understand the diverse changes and processes that occur in the course of parenting and under the new situations that subsequently develop within the context of depression. We believe that understanding the psychosocial process in such mothers based on the phenomenological view is important to gain significant possible directions for future support from nurses.

Thus, this study aimed to explore the psychosocial process in mothers who had continued fulfilling parenting responsibilities despite their depressed status.

Methods

1. Study design

A qualitative and descriptive design with the Grounded Theory approach (GTA) interpreting the phenomenon was employed to fulfil the study objectives. The GTA aims to depict informal roles of each character, interpersonal and person-environment interactions, and the process leading to subsequent changes within the phenomenon of interest[20 21]. For these reasons, this approach was most suitable for providing information about the daily feelings and behaviors of mothers with depressed mood, thereby identifying issues to be addressed, and important experience and changes/processes necessary for continuous fulfillment of their parenting responsibilities.

2. Study participants

1) Participant selection process and selection criteria

Participant candidates were mothers who were residents of City A (a local city with a population of 100,000 and approximate 900 births), and who received follow-up care by nurses (e.g. consultation when necessary) for their depressive status (EPDS score ≥ 9) detected at a checkup (the one-month postpartum checkup and the 2–4-months postnatal checkup) held at the City A Public Health Center as part of the peripartum mental health support project.

The EPDS was developed by Cox et al.[7] to screen depression in women in the perinatal period, and the reliability and validity of the translated version into Japanese, by Okano et al.[22], have already been confirmed. This 10-item questionnaire asks the mental status on a 4-point scale (0–3) in the past seven days to obtain the total score (range, 0–30) : mothers scoring ≥ 9 are suspected of having postpartum depression.

Another candidate population was anxious mothers

requiring intervention by nurses, whose risk was detected at the time of City A-organized checkups, the newborn home visit and the four-month postnatal checkup. The inclusion of this population was based on previous studies showing that the tendency toward depression increased with the intensity of anxiety about parenting[23, 24].

2) Study participants

Twelve strong candidates who had met the above criteria were selected by public health nurses. The purposes and methods of the study and ethical considerations were explained to them directly by the author in the presence of public nurses in appropriate parenting classrooms. Eleven mothers agreed to participate in the study. As shown in Table 1, participants were all in their thirties or early forties, married, and mothers of one or two children. Six of 11 participants had an EPDS score ≥ 9 at either one-month postpartum checkup or newborn home visit, and the remaining five were highly anxious mothers who received parenting guidance to address their depressive mood, loss of interest and pleasure, sleep disturbance, irritability, and fatigue.

3. Interview

Interviews were mainly conducted between four months and 12 months postpartum, because it coincided with the common maternity leave period; thus, mothers were more likely to be the main caregivers to their babies. Semi-structured interviews included questions regarding incidents and issues that mothers had encountered while parenting, and measures and feelings towards them. Interviews were conducted in accordance with the guidelines shown in Table 2.

Baseline data, such as participants' age, family composition and age of family members, delivery places (close to their parents or not), and availability of helpers in parenting were collected from participants.

Dates and locations of interviews, lasting for 30–60 min, were decided depending on participant condition and schedule. Each participant was interviewed once. All participants, except one, consented to recording of their interviews using a digital voice recorder. The interview for the remaining one participant was recorded in writing.

4. Analysis

GTA comprises the following steps[25, 26].

(1) Careful examination of data followed by data fragmentation.

(2) Extraction of properties (perspective) and dimensions of properties, and subsequent labeling.

(3) Categorization of labels.

Table 1. Attributes of research participants

Participant	Age	Family members (Age Year)	Returning birth	Current childcare support person	Family situation	EPDS ※
A	Early 30s	Husband (Early 30s), Child (3), Child (4 months)	Yes	Mother, Husband		11
B	Late 30s	Husband (Late 30s), Child (4 months)	No	Husband, Parents-in-law		13
C	Late 30s	Husband (Late 30s), Child (6 months)	No	Mother		11
D	Late 30s	Husband (Late 30s), Child (8 months)	No	Mother	Husband is business bachelor	5
E	Late 30s	Husband (Early 30s), Child (2)、Child (9 months)	No	Husband	No exchanges with mother	10
F	Early 40s	Husband (Early 40s), Child (8 months)	Yes	Mother, Husband		8
G	Late 30s	Husband (Early 30s), Child (3), Child (10months)	No	Husband		5
H	Late 30s	Husband (Early 40s), Child (9 months)	Yes	Mother		16
I	Early 40s	Husband (Early 40s), Child (3), Child (12 months)	Yes	Husband	Parents live far away	16
J	Early 30s	Husband (Early 30s), Child (8 months)	No	Husband, Mother-in-law	Parents: Bereavement	5
K	Early 30s	Husband (Early 30s), Child (4)、Child (12 months)	No	Without	Husband is business bachelor、No exchanges with parents	5

※ EPDS score at either one-month postpartum checkup or newborn home visit.

Table 2. Interview guidelines

Questions
1) How have you been spending your time since your child was born? Please tell me about your thoughts and feelings.
2) Did you sometime feel down while looking after your child(ren)? What did you manage to do in such a situation?
3) Why do you think you are still managing to continue looking after your child(ren)?
4) Have you become aware of your abilities while continuing to fulfill your parenting responsibilities?

(4) Sorting of categories into the causal conditions (prior to the phenomena), the action/interaction (incidents and responses under certain circumstances) and the consequences (outcomes).

(5) Preparation of a diagram depicting linkage among categories by phenomena, wherein relationships among categories were determined based on properties and dimensions. Determination of the core category (positions in the center) and subcategories.

(6) Creating a storyline (theory) with concepts (properties, dimensions, labels, core category and subcategories) to explain the diagram.

(7) Theoretical comparison (comparing data and ideas) based on the data analysis results, followed by next-round data collection.

(8) Repeating steps 1–7 on the next dataset. Combining a newly prepared diagram (step 5) with the existing diagram (updated after analysis of each dataset) to prepare the combined category relationship diagram.

It must be noted that theoretical sampling (further data collection for property candidates, based on the diagrams and theoretical comparison) was not conducted in this study due to the participant criteria. The combined diagram was prepared based on all datasets, and was used in creating storylines explaining phenomena. To improve credibility by obtaining rich data, the selection process of study participants described above was carried out. Further, to improve plausibility of the analysis, the author participated in GTA training, and the analysis was supervised by specialists in the field of qualitative analysis.

5. Ethical consideration

Prior to obtaining signed consent forms, the purposes of this study were explained to participants verbally and in writing, informing them of the voluntary nature of participation, the right to withdraw from the study at any time, and that there would be no loss of benefits due to refusal to participate. Data was handled carefully to ensure anonymity. This study was approved by the Medical Ethics Committee of Kanazawa University (approval number: 682–1).

Results

1. Psychosocial process in mothers with depressed mood who continued fulfilling parenting responsibilities: emerging phenomena and associated concepts

We separately analyzed the data from six mothers who had one child and the remaining five mothers who had two children. Because almost the same results were obtained, we treated the data as a whole.

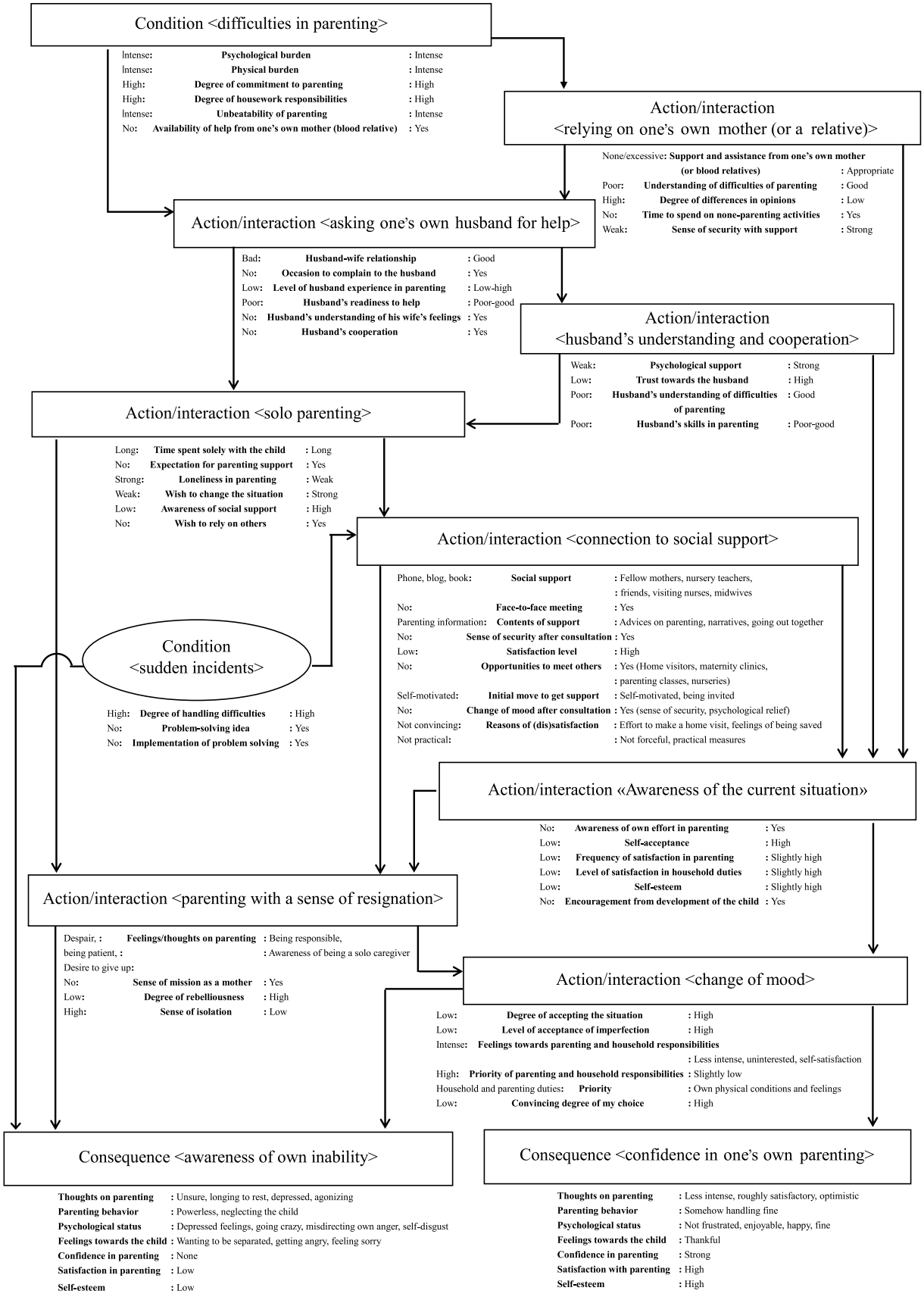
Core categories, subcategories, and categories extracted from individual datasets are shown in angled quotes («») , angled brackets (<>) , and curled brackets (｛｝) , respectively. Properties are shown in vertical bars (|) and are given with dimensions.

The core category was «awareness of the current situation», and its 11 subcategories were <difficulties in parenting>, <relying on one's own mother (or a relative)>, <asking the husband for help>, <husband's understanding and cooperation>, <solo parenting>, <sudden incidents>, <connection to social support>, <parenting with a sense of resignation>, <change of mood>, <awareness of own inability>, and <confidence in parenting>. A diagram depicting these 12 categories was prepared using properties and dimensions (Figure 1).

The following describes individual concepts and the psychosocial process in depressed mothers who continued fulfilling their parenting responsibilities.

1) Psychosocial process in mothers with depressed mood who continued fulfilling their parenting responsibilities: storylines (Figure 1)

Daily |physical burden| and |psychological burden| was intense in depressed mothers. |Unbearableness of parenting| was intense when |degree of commitment to parenting| and |degree of housework responsibilities| were high, and these underlaid feelings of <difficulties in parenting>. <Relying on one's own mother (or a relative)> was the first attempt made in obtaining support, which was replaced by <asking the husband for help> when |support and assistant from one's own mother| was excessive or none, or with no |availability of support from one's own mother|. Bad |husband-wife relationship| resulted in no |occasion to complain to the husband|, and poor |husband's readiness to help| led to <solo parenting>. Also, insufficient <husband's understanding and cooperation> and weak |psychological support| from the husband, as well as weak |trust towards the husband | led to <solo parenting>. Long |time spent solely with the child| with no |expectation for parenting support|, and intense |loneliness in parenting| led to <parenting with a sense of resignation>. After being patient despite intense |sense of isolation|, mothers became unsure about what to do with their children, and went into a negative spiral: from



※ Core categories, and subcategories, are shown in angled quotes («»), and angled brackets (<>), respectively. Properties are in bold, alongside dimensions of properties.

Figure1 Associative phenomena. A diagram depicting categories related to the «Awareness of the current status» phenomenon

depressed feelings and self-disgust, to <awareness of own inability> and actual inability in parenting. Still, during <solo parenting>, mothers tried to make a <connection to social support> with strong |wish to change the situation| and high |awareness of social support|. However, when |social support| provided |parenting information| only, but no opportunity of |face-to-face meeting|, mothers gained no |sense of security after consultation| with a low |degree of satisfaction|, which led to <parenting with a sense of resignation>.

However, mothers acquired «awareness of the current situation» with: appropriate |support and assistant from one's own mother (or a relative)|; good | husband–wife relationship|, strong |psychological support| from the husband, and strong |trust towards the husband|; and the presence of a |sense of security after consultation| and a high |satisfaction level| after having a <connection to social support>. These mothers managed to have a <change of mood> and |self-satisfaction| with |awareness of own effort in parenting| and high |self-acceptance|. Consequently, mothers became to have a high level of |satisfaction in parenting| and |self-efficacy|, which led to the <confidence in parenting> enabling them to address <difficulties in parenting>. Mothers with no |awareness of own effort in parenting| and low |self-acceptance| at the stage of the «awareness of the current situation» headed for <parenting with a sense of resignation>. Even under such situations, some mothers achieved the <change of mood> when they had |awareness of being a solo caregiver| with high |sense of mission as a parent|. An unsuccessful <change of mood> resulted in <awareness of own inability>.

Also, even when <relying on one's own mother (or a relative)> and parenting with <husband's understanding and cooperation>, <sudden incidents> occurred in their daily living. Response to <sudden incidents> with a high <degree of handling difficulty>, mothers with a | problem-solving idea| and |implementation of problem solving| made a <connection to social support>. On the other hand, mothers without those could not handle <sudden incidents>, immediately leading to <awareness of own inability>.

How mothers with depressed mood approach to people around and how they cope in feelings of difficulties in parenting led to different psychosocial process and consequences.

2) Descriptions of individual concepts

Concepts extracted from the pooled data of individual cases were described. Constituents of these concepts (concepts extracted individual datasets) are shown in Table 3.

(1) Difficulties in parenting

With <difficulties in parenting>, mothers don't believe that they fulfill their parenting responsibilities well, and feel challenged physically and psychologically. Depressed mothers are prone to tiredness. Participants in this study were with a depressed mood and tiredness from daily parenting, and found {physical and psychological burdens of parenting} and {extreme difficulties in fulfilling parenting and household duties}.

"At times, I could not laugh even when I was asked to. It was so hard (Participant F)."

Mothers were not sure how to handle issues and find appropriate parenting behaviors exemplified by the following: {having no idea how to respond to child's demand}, {having no idea how to do}, {continuously carrying my child, always carrying my child} and {having no option other than feeding}.

"My baby cried during the night and continuously during the day, didn't fall asleep easily, started crying immediately after being put down on the bed, so I had to carry the baby continuously, almost all the time (Participant C)."

Mothers were torn between responsibilities ({putting child matter first} and {demanding household duties}) and difficulties ({difficulties in finding time as planned/wished} and {having no spare time}). They had to be with their children all the time despite {their need for rest}, and consequently became psychologically trapped.

(2) Relying on one's own mother (or a relative)

<Relying on one's own mother (or a relative)> is a situation where mothers chose their own mothers or other family members with parenting experience as a primary support giver even when their husband's support was available. Such mothers (category examples: {relying on one's own mother} and {presence of a support giver}) gave birth somewhere closer to their parents, or visited their parents, thereby receiving support so that they

Table 3. Constituents of concepts

Core categories	Constituents (concepts extracted individual datasets)
Awareness of the current situation	To review parenting and household duties; Reviewing one's own effort; Awareness of own effort in parenting; Reflection on one's own parenting attitude; Encouragement from development of the child; Self-recognition as an immature mother
Subcategories	Components
Difficulties in parenting	Physical and psychological burdens of parenting; Extreme difficulties in fulfilling parenting and household duties; Having no idea how to respond to child's demand; Having no idea how to do; Continuously carrying my child; Always carrying my child; Having no option other than feeding; Performing parenting activities poorly; Putting child matter first; Demanding household duties; Difficulties in finding time as planned/wished; Having no spare time; Their need for rest; Parenting dilemma; Struggling to perform parenting activities
Relying on one's own mother (or a relative)	Relying on one's own mother; Presence of a support giver; Spending time at own parents' home; Arguing with parent; Being poorly understood by one's own mother; Restricted visit; Being unhappy about own elimination from parenting responsibilities; Loss of a role as a mother of the child; No parenting support from parents; Being refused and hugely shocked by refusal; No desire to rely on parents; No plan to rely on parents
Asking one's own husband for help	Full and unshared responsibilities in parenting; Husbands unsupportive in parenting; Husbands as those who have no knowledge about parenting; Need for recognition about how hard parenting is; Letting their husband know about their own feelings; Relying on one's own husband; Husband's lack of understanding
Husband's understanding and cooperation	Husband's support; Supportive husband; Persons who understand difficulties in parenting; Feeling secure to leave the child to; Husband who felt down on himself; Husband who plays with a child; Trustworthy husband; Free-to-talk husband-wife relationship; Recognition by my child and husband; Low recognition by the husband; Antagonistic husband
Solo parenting	Could not afford to make parents worry; The lack of help in parenting; No support give; Sense of parenting responsibilities; Only person fulfilling parenting responsibilities; Spending stressful time with a child; Hesitancy in leaving the child to the husband; Hesitancy in leaving the child to other people; Ending up doing by themselves; Feeling uneasy with excessive work involved in parenting and household duties
Sudden incidents	Continuous vomiting; Endless crying; Participants felt unsure about what to do; Worrying about whether to seek consultation
Connection to social support	A nearby counselor; Meeting with fellow mothers,; To have access to information about parenting; To have consultation; To follow examples; To use (public) parenting consultation service; To use telephone consultation service with their husband; To find a nursery position; Feelings of ease by talking; Feelings of relief after talking; Satisfactory feelings after having a consultation; To receive advice and support; To connect with support givers; Unsatisfactory consultation
Parenting with a sense of resignation	Feeling sorry for the child; An undervalued job (parenting); Parenting with a sense of resignation; Awareness of being a solo caregiver
Change of mood	Changing mood; The presence of good days and bad days in parenting; Not always aiming to be perfect; Sacrificing household work; Less intense parenting; Parenting at their own pace
Awareness of own inability	Exhaustion; Denial of solo parenting; Not being good at; Being incapable; Not trying hard enough; Not trying; Being discouraged by one's own performance in parenting; Being depressed; Denial of self as a caregiver; Child neglect
Confidence in one's own parenting	Themselves in good parenting; Own effort; Appropriately relaxed parenting; Optimistic; Confidence in parenting; Joy and happiness of being with family; Feelings of happiness of being with the child; Recognition of own husband and child; Sense of responsibility in parenting; Will to do more

could concentrate on parenting, or have some rest from parenting.

However, with disagreement in parenting approaches and support they wished to have, they experienced the situations of {being poorly understood by one's own mother}, {restricted visit}, {being unhappy about own elimination from parenting responsibilities} and {loss of a role as a mother of the child}.

"Well, I needed to stay up all through the night, but they said that since I was the one who chose to have a baby, they asked me not to disturb their day-to-day rhythms, but I felt physically exhausted and could not sleep when I wanted sleep, so I argued with my parents over such issues all the time (Participant E)."

Some mothers counted on their own mothers and other relatives, but faced the situations of {no parenting support from parents} and {being refused and hugely shocked by refusal}), while some had {no desire to rely on parents} or {no plan to rely on parents} based on previous experience.

(3) Asking one's own husband for help

<Asking one's own husband for help> is a situation where participants took some actions to gain support from their husbands, who were the only realistic support givers. Participants often felt that they had {full and unshared responsibilities in parenting} and found {husbands unsupportive in parenting}. Participants regarded husbands as {those who have no knowledge about parenting} with very little interest and experience in parenting. Husbands frequently did not help participants in parenting and household duties.

"[My husband] came back late, maybe around 7 pm or 8 pm. He said, "I'm back!" and went to see our child to play a bit while drinking beer (laugh). He seems to think that he works outside and I must look after our child (Participant C)."

Then, participants felt {need for recognition about how

hard parenting is}, and took some action for {letting their husband know about their own feelings}. When a certain level of understanding was expressed, participants began to be {relying on one's own husband}. However, when no interest was expressed, participants became to realize {husband's lack of understanding}, and then stopped asking them for help.

"[My husband] says that he does understand [parenting], but I don't agree with that (Participant H)."

(4) Husband's understanding and cooperation

<Husband's understanding and cooperation> is a situation where participants felt that their husband understood their difficulties in parenting and were ready to assist with parenting and household duties. Participants recognized their husbands as {persons who understand difficulties in parenting} and were {feeling secure to leave the child to>, when they could expect {husband's support}, or they felt that they had a {supportive husband}. Irrespective to the parenting skills of husbands ({husband who felt down on himself} vs {husband who plays with a child}), participants saw them as a {trustworthy husband}, established a {free-to-talk husband-wife relationship}, and felt {recognition by my child and husband}.

"I'm grateful if my husband keeps an eye on our child, even without doing anything proactively (Participant A)."

"My husband is someone who would help me, and in the end, he is the person who listens to me, and that makes a difference. It makes a difference on my mood whether or not I can have conversations with him (Participant J)."

However, some participants did not see that they were well understood by their husbands in the context of parenting (e.g. having {low recognition by the husband} and an {antagonistic husband}), and then stopped asking their husbands for help.

"Whatever I say [to my husband], something is wrong, and [he] has never said OK (Participant B)."

(5) Solo parenting

<Solo parenting> is a situation where participants felt {the lack of help in parenting} because they did not expect help from their parents and husbands, {could not afford to make parents worry} due to past reasons, and/or participants had {no support giver} available because their husbands worked away from home and their parents live far away or are deceased. With their strong {sense of parenting responsibilities}, they became the {only person fulfilling parenting responsibilities}, and their situation of {spending stressful time with a child} created a sense of stagnation.

"I didn't talk to anybody. It was hard, but I felt that I needed to do my best. I could not discuss anything with anybody, and I kept everything inside me (Participant H)."

"I cried a lot during the day. Being with just my child was too overwhelming, and I just get stressed myself (Participant F)."

Also, with little expectation of getting support from others and a tendency towards independence, participants had {hesitancy in leaving the child to the husband} and {hesitancy in leaving the child to other people} and tended to be in the situation of {ending up doing by themselves}, and then in the even harder situation of {feeling uneasy with excessive work involved in parenting and household duties}.

"I did too much [parenting and household duties], and then, it was me [who felt worse]. In the end, I'm the person who feel bad (Participant A)."

(6) Sudden incidents

<Sudden incidents> was a situation when unmanageable incidents occurred unexpectedly during parenting, such as the child's {continuous vomiting} and {endless crying} which could not be eased with known approaches, and consequently participants felt {unsure} about what to do.

"I try to think by myself why my baby does not stop crying. I don't hold it against my baby, but am just repeatedly thinking what should I do, what should I do. (Participant J)"

Participants then tried to find a way to get out from the unexpected challenging situation.

"At that time, I wondered, "Should I make a call, or

maybe I should not because my problem is too minor to discuss on the phone". (Participant D) "

(7) Connection to social support

<Connection to social support> was a situation where participants contacted social support, parenting classes and nurseries to solve parenting problems, and kept receiving support from them.

When solo-parenting participants knew about the social support, wished to ask others for support, and expected problem solving by receiving social support, they tried {to have access to information about parenting}, {to have consultation} and {to follow examples} through {a nearby counselor} and {meeting with fellow mothers}.

"Six close members of the parenting class gather every month and ask each other how everybody has survived another month. We often report whether recommendations from others went well or not. If a mother of two tells us about a successful example, we would follow that, and then report the outcome (positive or negative) at the following gathering. Then, I thought that I should also follow the example. That is actually a copy of other people who copy the example. (Participant I) "

Some participants chose {to use (public) parenting consultation service}, {to use telephone consultation service with their husband} and {to find a nursery position}. Some gained {feelings of ease by talking} and {feelings of relief after talking} with positive acknowledgment of social support (e.g. {satisfactory feelings after having a consultation}) . Then, they chose {to receive advice and support} and managed {to connect with support givers}.

"Maybe because I moved here, and really, I had nobody around. You definitely encounter something that you cannot handle by yourself, so the right connections did form, or I did gradually build them. (Participant K) "

However, some had {unsatisfactory consultation}, which led to <parenting with a sense of resignation>.

"Of course, I tried to discuss my issues with my mother, and with the hospital. I called up the hospital where I had delivered my baby, but I did not get satisfactory answers. (Participant D) "

(8) Awareness of the current situation

«Awareness of the current situation» was a situation where participants had time to review their own current parenting situation, and realized their own effort. With strong trust in support givers and a high sense of security and satisfaction in support given, participants managed to have time {to review parenting and household duties} under the current situation to have {awareness of own effort in parenting}. They accepted the situation even when the level of satisfaction in parenting and household duties were not as high as the level aimed, had {reflection on one's own parenting attitude}, and changed the mindset for tomorrow with {encouragement from development of the child}.

"I did my best at that time. I could not do any better. (Participant I) "

"I'm always angry with children, but have some enjoyable moments as well. When looking them smiling and sleeping, I feel calm, and every night, regret being angry with them. (Participant E) "

However, when participants who had low levels of satisfaction in parenting and household duties failed to recognize their own effort, they came to have {self-recognition as an immature mother}, leading to <parenting with a sense of resignation>.

"I repeatedly think, "Oh, I'm not really doing my best. I should have tried harder". (Participant B) "

(9) Parenting with a sense of resignation

<Parenting with a sense of resignation> was a situation where participants were not happy with their own parenting but could not find any alternatives, and just accepted how they were. They were {feeling sorry for the child}, but at the same time, they were unhappy about doing {an undervalued job (parenting) }. Then, they gave up trying to change their situation, and felt isolated, {parenting with a sense of resignation}.

"Well, conversely, I somehow feel sorry [for my children] when I'm with them. (Participant B) "

"When my husband comes back from work, our child,

who has been crying continuously, gets really excited. Then, I question what sort of role I am in. I look after the child with all my might, but all good things were taken away by somebody else. I'm forced to take over the tough parts of parenting, but others can just be affectionate and have fun, and of course, the child loves that. I feel that I'm doing a thankless job. (Participant F)"

"I cannot do anything because of the nature of the situation. I have to accept that nobody would come to help me, and think that I have to accept the situation. (Participant G)"

Participants managed to bounce back when they had a strong sense of mothers' responsibility with {awareness of being a solo caregiver}.

""I am the only person, nobody else would look after the child, then, I should look after the child", something like that. I'm doing it with a sense of duty (laugh). But really, who would do if I don't? (Participant F)"

(10) Change of mood

<Change of mood> was a situation where participants tried to change their perspectives to find positive aspects of parenting. Situations surrounding household and parenting duties did not change, but by {changing mood} to find the positive sides of parenting, participants came to accept {the presence of good days and bad days in parenting}, and began {parenting at their own pace} allowing them to have the attitude of {not always aiming to be perfect}, {sacrificing household work} and {less intense parenting}, which in turn boosted their confidence.

"Other problems have emerged [laugh], but if I cannot handle them well, then that is fine. I may think that the situation is helpless, but will accept it as it is, or give up. I can think in that way. (Participant C)"

However, the failure of {changing mood} led to the situation where participants became obsessed with implementation of parenting and household tasks.

(11) Awareness of own inability

<Awareness of own inability> was a situation where participants could not parent well, and consequently, became strongly depressed, accompanied by loss of confidence in parenting and low self-esteem.

After having unsatisfactory parenting experience and being frustrated in parenting and household duties, they became to fall into {exhaustion} with feelings of {denial of solo parenting}, leading to negative self-evaluation: {not being good at}, {being incapable}, {not trying hard enough}, and {not trying}.

"Hearing that [from other mothers] makes me feel that, really, I'm not good at it. (Participant F)"

Furthermore, when other negative feelings, such as {being discouraged by one's own performance in parenting}, {being depressed}, and {denial of self as a caregiver}, emerged, participants went into a negative spiral, involving {child neglect} and feelings of <difficulties in parenting>.

"I wanted to cry when I saw my child crying. (Participant C)"

"When my child did not stop crying, I did not do anything. Even though the crying continued, I did not know what to do. Whatever I was asked, I said, "I don't know, I have no idea". (Participant G)"

(12) Confidence in one's own parenting

<Confidence in one's own parenting> was a situation where participants were doing well in parenting at their own pace with strong confidence and self-esteem. They recognized {themselves in good parenting} and {own effort}, maintained the balance between fulfillment of parenting responsibilities and their own psychological state, and found their ability to do {appropriately relaxed parenting} with {confidence in parenting} and {optimistic} feelings.

"I have never had a chance to be with a baby before. So, honestly, I did worry if my baby could survive or if I wouldn't do anything fatal [laugh]. But now, I feel that I'm fine [about looking after my baby]. (Participant C)."

As a result, they found {joy and happiness of being with family} and {feelings of happiness of being with the child}, leading to {recognition of own husband and child} and the {will to do more} for their children based on the {sense of responsibility in parenting}. Then, they handled <difficulties in parenting>.

"The child has already come out of me, but still won't grow or develop unless I'm there, so I have to protect this child. That's how I feel. (Participant D) "

"I do sincerely thank my husband and child. It is true that I'm overwhelmed by parenting, but I'm still thankful for something that I gained only because I married and had a baby. So, I think I'll try hard tomorrow, too. (Participant E) "

Discussion

The process by which mothers with depressed mood continue fulfilling their parenting responsibilities were discussed with the emphases on the following two points.

1. Continuation of parenting from the situation of <parenting with a sense of resignation>

Mothers with depressed mood are fulfilling "lonely parenting" responsibilities[9,12,18] . This study also showed that depressed mothers experienced <solo parenting>, and went into a negative spiral of poorly conducted parenting with persistent depressed feelings. Depressed mothers felt helpless about the situation of <solo parenting>, and this led to the situation of <parenting with a sense of resignation> wherein they accept their dead-end circumstances. Some managed to bounce back, with the feeling of "being the only person for the child", and eventually gained confidence. The "sense of duty" as the person who gave birth to the baby, and the "sense of mission" as the person who would raise the child were the foundation of this belief. In the situation of <parenting with a sense of resignation>, participants felt isolated without available support, but the connection with their children appeared to remain. Mothers gradually form ties with their children through pregnancy and childbirth. They might have felt that their children were part of them, and thus, they took all the responsibility in parenting. However, upon repeated encounters with <difficulties in parenting>, the sense of duty and sense of mission appeared to be replaced by a "sense of obligation" easily, which could cause frustration and abandonment, leading to the negative spiral about continuation of parenting.

Mothers with depressed mood have parenting abilities. However, compared to healthy mothers, they were further on the edge of breaking down under |physical | and |psychological burdens|, which is in good agreement with the findings of a previous study[13] . Mothers without external support were shown to be at a high risk of having problems in parenting[23] , but they have such a strong sense of resignation that it is rare for them to seek out parenting help by themselves[9] . Being in the situation of <solo parenting> with no peace of mind, depressed mothers cannot escape from falling into the negative spiral, enhancing their depression and anxiety levels.

Depressed mothers have limited capabilities in fulfilling their parenting responsibilities continuously.

2. Necessary support for continuation of parenting: help from one's own mother, husband, and social supports

«Awareness of the current situation» was the key to break the negative spiral and gain confidence in parenting. The following describes what mothers with depressed mood would like to receive from one's own mothers, husbands and social support, to reach the «awareness of the current situation».

The mothers wished to receive "support to prevent exhaustion", such as help in housekeeping, care for themselves, and assistance in parenting, from their own mothers so that they could focus on parenting. They expected to receive concern-free support from their mothers, instead of interactions that would consume their mental energy.

Depressed mothers did not demand much from their husbands, but wished to receive "psychological support". They wished to have understanding and cooperation in the challenging task of parenting from their husbands. Quality or quantity of help in parenting and housekeeping were not questioned. Their major concern was whether their husbands understood how difficult and painful they felt when parenting. Once they believed that husbands understood their feelings, they trusted their husbands and gained psychological stability and composure to view the situation calmly and positively.

Generally, mothers with depressed mood see their own mothers and husbands as primary support givers. This study revealed that they expected physical, logistical support from the former and psychological support from the latter. It was previously reported that husbands' support boosted self-esteem in mothers fulfilling parenting responsibilities[27] , while the recognition of the lack of support impaired their mental health[28] . Satisfactory support from husbands eased mothers' depression, anxiety[23] , and struggle in parenting[29] . Also, the husband–wife relationship influenced their depressed

status[16, 30], and psychological support from husbands influenced the severity of depression[31]. Taken together, psychological support from husbands plays a pivotal role in depressed mothers to continue fulfilling their parenting responsibilities.

The mothers wished to have face-to-face support services that ease their loneliness and sense of isolation. Emphatic support, sharing feelings with other mothers in similar situations, having model behaviors, and support in case of <sudden incidents> comforted depressed mothers and eased their loneliness and sense of isolation. This is in good agreement with the study by Ni[32], which found effects of support from fellow mothers. The absence of support givers and loneliness negatively affects mental health in mothers[18, 31]. However, even they are unbearably lonely[12], depressed mothers do not voluntarily seek help[9], perhaps, not because they are sensitive, but because they have already given up on their present situation. Depressed mothers do not expect anybody to give them help. If support from one's own mothers and/or husbands is unsatisfactory, they seem to accept that they are the ones who have ended up looking after their child, and thus, that there is no point making any calls for help. However, face-to-face support appears to satisfy and comfort them, indicating that public health guidance offered by the government, even that regarded semi-compulsory, is effective in rescuing depressed mothers from isolation. It is noteworthy that the lack of support in case of challenging sudden incidents directly put them in the situation of having <awareness of one's own inability>. It is important to raise awareness of availability of social support so that depressed mothers, even not using the service regularly, see the use of service as a practical action.

Application to Nursing Practice

«Awareness of the current situation» was crucial to break the negative spiral and to gain confidence in parenting. Yamamoto[33] reported that the level of anxiety became lower as the level of awareness increased. To stabilize mothers with depressed mood and help them continue fulfilling their parenting responsibilities, providing their mothers and husbands with appropriate guidance might be effective. Also, it is better to visit such mothers directly to provide social support for relief of loneliness and isolation. When social support reaches them, they are often at a very fragile state, but are still trying to fulfill parenting responsibilities. Judgement of the need for support and the system enabling immediate action are necessary.

Limitations and Challenges of the Study

Participants of this study were mothers who were referred by public health nurses of certain public health centers, and thus, the possible influences of regional characteristics and heath guidance provided cannot be eliminated. Also, because theoretical sampling was not performed as described earlier, theoretical saturation may not be reached. Analysis of more data is necessary. In particular, it would be significant to know how mothers' feelings towards their children influence their sense of duty and sense of mission, and how they relate to the continuity of parenting.

Conclusion

The mothers found <difficulties in parenting>, and ultimately reached a state of either <awareness of own inability> or <confidence in one's own parenting> through various routes. For example, depressed mothers, without help from their own mother and/or husband, felt lonely and isolated in <solo parenting>. Gaining «awareness of the current situation» was a decisive point. Those that gained awareness of their own effort became able to have a <change of mood> and <confidence in one's own parenting>, while those that did not gain awareness of their own effort underwent <parenting with a sense of resignation>, leading to <awareness of own inability>. Upon encounters with difficult <sudden incidents> during parenting, the lack of <connection to social support> immediately led depressed mothers to <awareness of own inability>.

Acknowledgements

I thank participants who kindly agreed to participate in this study, and people at cooperating centers.

References

1) Okano T：Sango utsubyou no genjyou to chiryou; Seibutsugakuteki youin to syakaisinrigakuteki youin no kanren kara. Journal of Japanese Society of Psychosomatic Obstetrics and Gynecology 5 (1) : 17-23, 2000 (in Japanese)
2) Takahashi S, Ohno Y, Someya T, et al: Diagnostic and Statistical Manual of mental disorders, Fifth edition. American Psychiatric Association, Igakushoin, pp 160-186, 2014 (in Japanese)
3) Kumar R: Postnatal mental illness; Transcultural perspective. Social Psychiatry and Psychiatric Epidemiology 29: 250-264, 1994
4) O'hara MW, Swain AM: Rates and risk of postpartum depression; A meta-analysis. International Review of Psychiatry 8: 37-54, 1996
5) Okano T, Sugiyama T, Nisiguchi U：Syuusanki kara boshi eno mentaruherusu sapouto puraimarikea ni okeru sangoutsubyou no sukuriningu sisutemu ni tsuite. Japanese Journal of Maternal Health 48 (1) : 16-20, 2007 (in Japanese)
6) Suzumiya H: Hokenkikan ga zissi suru boshihoumon taissyousya no sangoutsubyou zenkoku ta-syisetsu tyousa. Kousei no Sihyou 51 (10) : 1-5, 2004 (in Japanese)
7) Cox JL, Holden MJ, Sagovsky R: Development of postnatal depression; Development of the 10-item Edinburgh Postnatal Depression Scale. British Journal of Psychiatry 150: 782-6, 1987
8) Yamashita H: Sangoutsubyou no hahaoya eno shien. Perinatal Medicine 38 (5) : 545-549, 2008 (in Japanese)
9) Fujino Y: A qualitative study on the child rearing experience one month after childbirth of postnatal mothers who became depressed one month after delivery. Japan Society of Maternal Health 53 (2) : 259-267, 2012 (in Japanese with English Abstract)
10) Suzumiya H, Yamashita Y, Yosida K: Baby care support and intervention using the self − report questionnaires to the postnatal mothers. The Japanese Society of Child Health 67 (4) : 641-647, 2008 (in Japanese with English Summary)
11) Tamaki A: Postnatal mental health and social support. University of Hyogo, College of Nursing art and Science, Research Institute of Nursing Care for People and Community bulletin 14: 37-56, 2007 (in Japanese with English Summary)
12) Beck CT: The lived experience of postpartum depression; A Phenomenological Study. Nursing Research 41 (3) : 166-70, 1992
13) Beck CT: Teetering on the edge; A substantive theory of postpartum depression. Nursing Research 42 (1) : 42-8, 1993
14) Beck CT: Postpartum depressed mothers' experiences interacting with their children. Nursing Research 45(2): 98-104, 1996
15) Edhborg M, Friberg M, Lundh W, et al: "Struggling with life"; Narratives from women with signs of postpartum depression. Scandinavian Journal of Public Health 33 (4) : 261-7, 2005
16) Highet N, Stevenson AL, Purtell C, at al: Qualitative insights into omen's personal experiences of perinatal depression and anxiety. Women Birth 27 (3) : 179-84, 2014
17) Shin S, Yamada K, Morioka I: Feelings of difficulty with child-rearing and their related factors among mothers with a baby at the age of 2-3 months. Japan Society of Nursing Research 38 (5) : 33-40, 2015 (in Japanese with English Abstract)
18) Matsubara N, Hotta N, Yamaguchi T: The longitudinal study on the depressive state of mothers in the childbearing period. The Japanese Society of Child Health 71 (6) : 800-807, 2012 (in Japanese with English Summary)
19) Tokuhiro Y, Mishina H, Arimoto A: A population-based survey of mother-to-infant bonding disorder; Analysis of questionnaire in group well-child care visits. The Japanese Society of Child Health 74 (4) : 556-562, 2015 (in Japanese)
20) Glaser BG, Strauss AL/Gotou T, Ode H, Mizuno S: The discovery of Grounded Theory; "Strategies for qualitative research" (1967) , Sinchousya, pp 1-63, 1996 (in Japanese)
21) Saiki CS: Gissen guraundeddo seori apurouchi gensyou o toraeru. Sinchousya, pp 6-7, 2008 (in Japanese)
22) Okano T, Murata M, Masuji S, et al: Validation and reliability of Japanese version of EPDS (Edinburgh Postnatal Depression Scale) . Archives of Psychiatric Diagnostics and Clinical Evaluation 7 (4) : 525-533, 1996 (in Japanese)
23) Kanzaka M: The impacts of childrearing problems and family function for childrearing difficulty in mothers at one month postpartum. Journal of Japanese Society of Psychosomatic Obstetrics and Gynecology 19 (2) : 176-188, 2014 (in Japanese)
24) Shigemoto M, Narama M, Asano M: Mothers' perceptions of their infants' conditions and their feelings of difficulty with child rearing. The Japanese Society of Child Health 69 (6) : 781-789, 2010 (in Japanese with English Summary)
25) Saiki CS: Guraundeddo seorii apurouchi bunseki wakubukku. Nihonkangokyoukai syuppankai, pp 5-7, 2014 (in Japanese)
26) Saiki CS: Guraundeddo seorii apurouchi kaiteiban riron o umidasu made, Sinchousya, pp 28-44, 2016 (in Japanese)
27) Yoshida Y, Maruyama T, Sugiyama A, et al: The state of psychosocial of women during pregnancy and 2 years after delivery; The state of psychosocial of postpartum women. Journal of Japanese Society of Psychosomatic Obstetrics and Gynecology 6 (1) : 100-

107, 2001（in Japanese with English Summary）
28）Nakabayashi M, Teranishi K, Niikura M, et al: A change in the degree of the mental health condition of mother with infants; The follow-up survey until an infant was 18 months from 4 months. Japan Society of Maternal Health 46（4）: 655-665, 2006（in Japanese with English Abstract）
29）Fujioka N, Kato N, Hamada M: The fact-finding concerning the difficulties of rearing of women with one-year-old children and the satisfaction with their husband's participation in childcare. Japan Society of Maternal Health 54（1）: 173-181, 2013（in Japanese with English Abstract）
30）Yamagochi F, Tagawa K: Hahaoya no sangoutsu keikou ni eikyou o ataeru youin; Sango 5 nichi kara 6 kagetsu no jyudanteki chousa kara mietekita koto. International Nursing Care Research 15（3）: 23-32, 2016（in Japanese with English Abstract）
31）Ohno H: Sangoutsujyoutai ni kansuru kenkyu（dai 1 pou）; Sango 1 kagetsu no hahaoya no kokoro no jyoutai to otto no seisinteki sien tono kankei. Bulletin of Aichi Medical University, College of Nursing（7）: 1-13, 2008（in Japanese with English Abstract）
32）Ni PK, Siew Lin SK: The role of family and friends in providing social support towards enhancing the wellbeing of postpartum women; A comprehensive systematic review. Joanna Briggs Institute Library of Systematic Reviews 9（10）: 313-370, 2011
33）Yamamoto N, Naruse A, Nagata T: Hahaoya no maindofurunes to sango no yokuutsusyoujyo no kanren ni tuite. Iryou no Hiroba 56（2）: 21-25, 2016（in Japanese）

抑うつ状態にある母親の育児継続に関する心理社会的プロセス

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要　　旨

目的：抑うつ状態にありながらも育児を継続している母親の心理社会的プロセスを明らかにする。

方法：産後１か月健診時または生後２～４か月の新生児家庭訪問時、エジンバラ産後うつ病自己調査票による抑うつ状態が疑われる９点以上の高得点者あるいは、育児不安が強く抑うつ傾向が高いと判断された母親11名に半構成的面接を行った。分析にはグラウンデッド・セオリー・アプローチを用いた。

結果：抑うつ状態にある母親は、日々≪子どもへの対応の困難さ≫を感じていたが、その後に辿るプロセスはさまざまな形を呈しており、最終的に≪できない自分の自覚≫あるいは≪子どもの対応への自信≫のどちらかに至っていた。母親は身近にいる実母や夫からの支援や理解が無いと≪自分ひとりの育児≫となり、孤独な孤立した育児となっていた。しかし、育児プロセスの中で【現状への気づき】ができるかどうかが重要な分岐点となっていた。現状の自分の頑張りに気づけた場合は≪気持ちの切り替え≫ができ≪子どもの対応への自信≫となっていた。自分の頑張りに気づけなかった場合は≪あきらめの育児≫となり≪できない自分の自覚≫となっていた。また育児中、対処困難な≪突発的な出来事≫が起こった時、≪ソーシャルサポートとつながる≫ことができないと、直ちに≪できない自分の自覚≫となっていた。

考察：抑うつ状態にある母親が自ら持つ育児能力だけで育児を継続するには限界がある。抑うつ状態にある母親が安定して育児継続できるためには、支援者である実母には疲弊防止の支援、夫には精神的サポート、ソーシャルサポートには孤独感・孤立感の解消が求められていることが示唆された。