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Women's experiences of health visitor delivered listening visits as a treatment for postnatal depression: A qualitative study

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ABSTRACT

Objective: To explore women's experiences of health visitor delivered listening visits as a treatment for postnatal depression.
Methods: In-depth interviews with 22 women who had received listening visits as a treatment for postnatal depression.
Results: All the women reported the visits as beneficial, although many of them had required additional intervention to manage their symptoms. Women who had a previous history of depression and women whose depression was not attributed to events in the postnatal period perceived the listening visits to be less beneficial. Receiving visits from a research health visitor, rather than their practice health visitor, was felt to be advantageous.
Conclusion: Women with postnatal depression may report listening visits as helpful but insufficient to manage their depression. The extent to which women report listening visits as beneficial appears to be linked to the causes of their depression, the way in which the visits are delivered and by whom.
Practice implications: Practitioners managing women with postnatal depression should discuss possible causes and previous episodes of depression before suggesting listening visits as a treatment. They need to explain what the visits will entail, ensure that additional types of treatment remain available and encourage women to utilise other forms of support.

1. Introduction

Postnatal depression (PND) is a substantial public health problem, affecting about 13% of newly delivered mothers [1]. Most women diagnosed with PND are managed in primary care and treatment options include antidepressant medication, psychological intervention or a combination of both. Although antidepressants are usually the most accessible treatment available to women with PND, the National Institute for Health and Clinical Excellence (NICE) advocates the use of psychological therapies as the first line treatment [2].

In many countries, listening visits are widely used as a treatment for PND [3]. They utilise a form of non-directive counselling that originates from client-centred psychotherapy [4] and have been shown to be an effective treatment for PND [5–8], although long term benefits on maternal mood have not been established [7]. In the UK they are usually delivered by health visitors, who are qualified nurses or midwifes specifically trained to assess the health needs of individuals, in particular the needs of new parents and children under the age of five. Depending on the Primary Care Trust they are employed by, their training will cover how to counsel and support women with PND.

We have very limited understanding of women's experiences of listening visits. Holden et al. [5] interviewed women who had received listening visits during their trial of this treatment but presented very little of the resulting data. Since then, only Shakespeare et al. [9] have assessed women's views and experiences of listening visits for PND. Some of the women they interviewed had not scored more than 12 on the Edinburgh Postnatal Depression Scale (EPDS) at 8 weeks and/or 8 months postnatal, suggesting that they may not have had PND, and women were defined has having received listening visits even if they had received just one visit. Thus, research with women who had been diagnosed with PND and received a course of listening visits could provide new insights into how women feel about this therapeutic approach and how it might be modified to increase its effectiveness. This paper reports findings from in-depth interviews with women who had been diagnosed with PND and had received four or eight listening visits, to explore their views and experiences of this treatment.

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2. Methods

2.1. The RESPOND trial

Interviews were held with women who had taken part in RESPOND (Randomised Evaluation of antidepressants and Support for women with POstNatal Depression). RESPOND is a randomised controlled trial that aims to compare the effectiveness of antidepressants and listening visits delivered by research health visitors (RHVs), for the treatment of PND. The trial design allowed women randomised to listening visits to approach their GP at anytime for antidepressants, and women allocated to antidepressants to receive listening visits any time from 4 weeks post-randomisation.

Women were recruited to RESPOND through 77 collaborating GP practices in three UK cities. Between January 2005 and August 2007, all recently delivered women registered with a participating practice who were over the age of 18 and living with their baby, were invited to take part. Women were eligible for entry to the trial if, at about 8 weeks post-partum, they scored more than 12 on the 10-item EPDS [10] and received an ICD-10 primary diagnosis of major depression having completed a computerised Clinical Interview Schedule (Revised) (CIS-R) [11]. In addition to this method of recruitment, participating GPs and health visitors could also refer women between 6 and 26 weeks postnatal. These women were eligible for entry if they fulfilled the same EPDS and CIS-R criteria.

Women randomised to listening visits received a series of 4 weekly listening visits. The visits took place in the woman's home and lasted no more than an hour. At the fourth visit, the RHV and woman reviewed progress and decided whether the individual needed to receive a second set of 4 visits. Women were offered up to eight visits, as discussions with health visitor leads in the three cities suggested that this would parallel current clinical practice.

Each trial centre employed an experienced RHV to deliver the intervention. The three RHVs attended formal training organised by a consultant clinical psychologist, using a previously developed and evaluated training package [12]. Training comprised two full-day sessions and covered the detection, treatment and prevention of PND, and the value and practice of non-directive counselling. Subsequently, each RHV received regular peer supervision from a local community mental health nurse and, as a group, ongoing guidance from the clinical psychologist. To ensure consistency in their approach, the RHVs developed a protocol with the psychologist and were in regular contact with each other throughout the trial.

2.2. The interviews

Women were interviewed after their final outcome measures for the trial had been completed, i.e. at 44 weeks post-randomisation. A purposeful sampling approach was used to ensure interviews were held with women who had received listening visits during the trial and were living in different cities. Within this sampling approach, we aimed for maximum variation in relation to age and socio-economic background. The interviews were conducted by one of the authors (LF) using a topic guide. The guide consisted of a series of open-ended questions that related to a number of topic areas (Box 1). During each interview, LF asked each question to ensure consistency across the interviews, whilst also being flexible about the ordering of the questions asked and allowing participants to raise issues salient to them.

Between November 2006 and June 2007, 22 women were interviewed in total (Table 1). One individual had received four visits and the remaining women had received eight visits. Two participants were interviewed over the telephone. The remaining participants were interviewed in their own homes. The interviews lasted between 40 min and 2 h. Data collection and analysis proceeded in parallel, and recruitment to the qualitative study ended when no new findings were emerging from analysis of the later interviews, indicating that data saturation had been reached.

Box 1. Areas covered in the topic guide

- Experience of postnatal depression.
- Expectations of the trial.
- Expectations of the treatments offered.
- Experience of receiving listening visits.
- Relationship with RHV and support received.
- Other treatment received during the trial.
- Experience of ending the listening visits.

2.3. Data analysis

Each interview was audio taped and fully transcribed. Transcripts were then read and re-read in order to gain an overall understanding of the women's views and experiences, to identify emerging themes and to develop a coding frame. Transcripts were read by different members of the research team, so that the analysis and coding frame could be refined through discussion.

Transcripts were imported into the software package NVivo to allow electronic coding and retrieval of data. Several transcripts were independently coded by KT and LF, who then met to discuss areas of consensus and discrepancy. This led to further codes being developed and to existing codes being defined more clearly. Once all the transcripts had been coded, data were analysed using a framework approach [13]. Using this method, what participants had said in relation to specific issues, e.g. the RHV's approach, was summarised in tables and comparisons then

Table 1
Characteristics of the women interviewed having received listening visits ($n = 22$).

Age range	19–45 years old
Study site	
Bristol	7
Manchester	8
London	7
Ethnicity	
White	16
Pakistani	1
Indian	1
Black Caribbean/Africa/other	4
Highest qualification achieved	
Degree	10
A-level	2
GCSE	9
NVQ	0
None	1
Socio-economic classification[a]	
Higher managerial and professional occupations	6
Lower managerial and professional occupations	3
Intermediate occupations	1
Small employer and own account workers	1
Lower supervisory craft and related occupations	0
Semi-routine occupations	4
Routine occupations	1
Not currently in paid employment	6
Previous depression	12
EPDS scores at baseline	
Mean score	17.6
Range	14–26

[a] Based on the National Statistics Socio-economic Classification. http://www.statistics.gov.uk/methods_quality/ns_sec/.

made both within and across interviews to identify thematic patterns and deviant cases.

The study was approved by the Multi-Centre Research Ethics Committee (MREC) Scotland A (06/MRE00/54).

3. Results

3.1. The listening visits

All the women reported the visits as beneficial. Analysis of the data suggested that the reported benefits related to the opportunity to talk provided by the visits, the women's relationship with their RHV, and the support given by their RHV.

3.1.1. The opportunity to talk

Some women described the visits as the only setting in which they had been able to discuss their feelings and situation. It was evident that one reason for this was because women had told no-one or very few people about their depression:

> "I didn't have anyone to talk to and no one actually knew about me being diagnosed with postnatal depression, my mum or anyone, no one knew, not even my partner. So it was quite nice just to offload on someone."

Individuals explained that they had not told friends and family because they felt they should be coping or feared being judged as a poor mother. Women also recalled how they had not consulted their GP or practice health visitor (PHV), i.e. the health visitor provided through their general practice. They had thought their GP would simply prescribe antidepressants, a treatment they did not want, and that their GP and PHV did not have the time to listen. When discussing their PHV, there was also the suggestion that women felt it would have been inappropriate to have focused on themselves, rather than their child.

> "With the health visitor you feel, well I can't have everything round me because that looks selfish, I have a new child here, you know, I need to be focusing on my new child, not myself and how I might be feeling."

The idea of the visits providing women with an opportunity to talk was also implied by the way in which women described the visits as having a specific focus on them and their situation.

> "When like [RHV name] came to see me, it was nice because it was like my time and our time and we could talk and stuff."

In addition, women described how they had been allowed to set the boundaries of the discussions and to focus on what they wanted. Women had talked not only about their experiences of motherhood and feelings towards their child, but also about their expectations of themselves, relationships with partners and relatives, and financial concerns.

3.1.2. Relationship with the RHV

A few women said they had initially found it difficult to talk to their RHV because they were unsure of what to expect or did not find it easy to discuss their feelings. However, most of the women described how they had felt comfortable talking to their RHV from the start and all the women, including those who had initially struggled to talk, detailed how they had been able to confide in their RHV.

Women reported their RHV's personality and approach as having encouraged them to talk. They described their RHV as being kind, non-judgemental and understanding, and as giving praise and encouragement. Women also mentioned that they felt comfortable confiding in the RHV because she was not attached to their GP surgery. In their view, this meant their GP and PHV would not be informed about what had been discussed. It was also felt that information was less likely to get back to people they knew.

> Interviewer: "You don't think you'd have talked to your own health visitor about it in the same way or about those things?"
>
> Participant: "No."
>
> Interviewer: "Why do you think that is?"
>
> Participant: "I mean my health visitor, she's lovely and I really, really like her but so many people have her as a health visitor... I know she wouldn't say anything but you know it could just come out and I didn't really want that I suppose, it's too close to home."

Many of the women contrasted their relationship with their RHV to the relationship they had with their PHV. Whilst a few women stated that the visits would have 'worked' with their PHV, most of the women felt this would not have been the case. A few women said they did not have a good relationship with their PHV having found her critical of the way they were parenting or rather brisk in her approach. Women also commented that their PHV did not have time to listen nor visit them at home. Many of the women commented that with their RHV, they knew they had an hour to talk and having the visits at home meant they could talk in private, in the comfort of their own home, and did not need to worry about going out, being late for the appointment and what facilities would be available for entertaining or feeding their child. Women also talked about their RHV being particularly good at listening and attributed this to the fact that she had received specific training in listening skills. In addition, women talked about being more careful about what they said to their PHV, explaining that they felt she would be more likely to judge their ability to mother.

> "With [RHV] I feel like I could have just said what I wanted, how I wanted, if you see what I mean and I could cry with [RHV] but with my health visitor, I try not to let too much out because then she won't think I'm a bad mum."

However, there were also women who commented that they had been careful about what they said to their RHV, acknowledging that she also had a responsibility to ensure the child's wellbeing.

3.1.3. Support given by the RHVs

The women's accounts indicated that the RHVs had listened carefully and reflected back to the individual what she had said; asked questions to encourage the individual to describe exactly what was happening; explained that what the individual was experiencing was a symptom of PND; and reassured the individual by saying she would feel better with time. Women also mentioned that their RHV had made suggestions that they thought the individual might find helpful, e.g. lower expectations of self, and had given practical help and support, e.g. referred the individual to parenting classes.

Women detailed how the RHVs' responses had allowed them to "*offload*", "*unlock issues*" and share their concerns; clarify and reconsider their thoughts; gain insight into their PND and a different perspective on issues that had concerned them; and some

ideas about how to manage their situation. In addition, one woman described how she had gained a better understanding of what was happening and thus, had felt less scared:

> "I was very scared because I didn't understand why I was doing things and thinking things and feeling things and she [RHV] put things in to words... I started being more aware of what was happening to me and then it made it a bit less scary."

Some women described the visits as having been key to their recovery. Yet a few of the women talked about how they would only feel better for a few days following a visit, and four women reported having started taking antidepressants during the course of the visits because their mood had remained low. In addition, over half of the women described how they felt eight visits had not been enough to address their PND.

3.1.4. Ending the visits

Fourteen of the 22 women stated that eight visits had not been sufficient. These women detailed how after the visits had ended, they had gone on to take antidepressants, continued to take antidepressants that they had started prior to or during the visits, or had organised counselling privately or through their GP.

When comparing the accounts of women who commented that eight visits had not been sufficient with those who reported eight had been enough, in contrast to the latter group, it appeared that women who had wanted further visits were individuals whose PND did not relate primarily to their postnatal circumstances. These women described how they had felt depressed before their pregnancy, explained how they had experienced depression or PND in the past, or mentioned that the birth of their child had raised memories of past negative events, e.g. terminating a pregnancy. In contrast, the women who felt four or eight visits had been sufficient, related their PND to a hormonal imbalance, needing to adjust to parenthood, having a particularly difficult time following the birth of their child, or to problems that had now been resolved, e.g. relationship difficulties. It was also apparent that some of these women, whilst receiving the visits, had put other sources of support in place, e.g. they had started parenting classes and made new friends.

During the interviews held with women who had felt a need for additional treatment, some women talked about how they had been angry that the visits had ended, and individuals described how they felt they been "*left hanging*" and "*completely exposed*". In addition, it was argued that if no further support had been available through the GP, the visits would have been pointless:

> "Just me thinking about it [the idea of no treatment after the visits] now makes me feel quite panicky... what would have been the point of ripping off the plaster and starting to abrade the wound, only to then just say, oh well."

4. Discussion and conclusion

4.1. Discussion

Women interviewed for this study reported that they had benefited from receiving listening visits as a treatment for PND. The benefits they described stemmed from having an opportunity to talk and focus on their own feelings and circumstances, and from receiving support from a practitioner whom they felt able to confide in, and who had the skills to provide both emotional and practical support. These benefits may partly be explained by the visits being delivered by a RHV rather than the women's PHV, as they had time to focus primarily on the mother and were viewed by the women as independent of their GP surgery and thus not in contact with their peers or their GP. In keeping with other literature [9], we also found that women appreciated talking to someone who had time to listen and whom they found to be non-judgemental and empathic.

It was apparent that the opportunity to talk could be a particularly valuable experience for women with PND, as there was evidence of women being reluctant to discuss their depression due to fears about being judged [14]. We suggest that through talking, women developed insight into their situation and emotions, and gained knowledge about the causes and effects of PND. Practical advice given by the RHV also armed women with specific coping strategies and enabled them to access other services.

However, some women reported that eight visits had not been sufficient to address their symptoms. Analysis of our data suggested that listening visits were subjectively most effective for women whose PND was related to life events and changes in the postnatal period, and who had been able to put other forms of support in place whilst receiving treatment. They were subjectively less effective for women who had experienced depression in the past or whose life situations remained unresolved. Other studies have also found women with a history of depression as not reporting listening visits as beneficial [9], and it has been argued that PND occurring in the context of a continuum of poor mental health may be of 'biological' origin and less likely to respond to psychosocial intervention [5].

Although listening visits have been found to be an effective treatment for PND [5–8], it was notable that many of our participants reported the visits alone as not sufficient. It is possible that being in a trial where antidepressants were available had encouraged women to consider additional treatment; indeed RHVs were reported has having encouraged women to consider taking medication where necessary [15]. It is also possible that by interviewing women some time after the visits had finished, we might have missed the point at which women experience most benefit. Certainly Cooper et al. [7] found that listening visits improved maternal mood immediately following treatment but that treatment benefits were no longer evident by 9 months post-partum. Considering women with PND are more likely than women who do not develop PND to experience marital conflict [16], perceive a lack of social support [17], and have a personal history of psychiatric illness [18], it is perhaps not surprising that some of our participants did not view eight visits as sufficient.

Women's descriptions of their relationship with their PHVs raised questions as to whether health visitors are best placed to deliver listening visits. Training has been developed to enable health visitors to detect and treat PND [19,20]. Even limited training can improve their counselling skills [21] and health visitors can be more effective than treatment specialists in providing home-based interventions for PND [7]. However, like others [9], we found that some women did not report a good relationship with their PHV. We also noted that women benefited from being visited at home and having visits that focused specifically on their needs as opposed to the baby's, and PHVs were described as being too busy to provide such support. It was also apparent that when talking to their PHV, concerns about confidentiality and being stigmatised as a 'poor' mother were heightened. It has been reported that health visitors themselves see the move towards corporate working [22] as limiting their availability for women with PND [23] and the fact that in the UK, health visitor numbers have fallen to their lowest number since 1994 [24] suggests resources in this area are limited.

Our study also highlighted that alternative treatments for PND need to remain available to women receiving listening visits, both during and after the visits have ended. NICE [2] does suggest the use of antidepressants if psychological therapy does not work or if the individual has a history of severe depression. Although women with PND are usually reluctant to take antidepressants [14,25,26], their views towards medication can change and they may accept drug treatment having not responded to listening visits [15].

Interviewing women one year after the birth of their child placed us in a good position to explore women's views about the short and long term effectiveness of listening visits. However, this did mean their accounts were open to recall bias. It is also possible that we sampled from a biased group of women, as women with PND may refuse to take part in trials because of their concerns about antidepressants [27]. The purposeful nature of the sampling strategy used will also have limited the extent to which findings can be generalised.

4.2. Conclusion

Women may report listening visits as helpful but insufficient to address their PND. The extent to which women view this treatment as beneficial appears to be affected by the underlying cause of their PND and their susceptibility to poor mental health in general. Our findings suggest that practitioners providing listening visits need to have the time and skills to listen and provide support, and that women will benefit most if they feel that the visits are an opportunity for them to discuss their own needs and to talk in confidence, without being judged and knowing that information will not be passed on to their GP or PHV. Future research could assess whether PHVs are best placed to deliver listening visits to women with PND, whether providing more than eight visits would enhance the effectiveness of this treatment, and whether this treatment is less effective for women with a history of depression.

4.3. Practice implications

GPs making a diagnosis of PND should explore with the woman possible precipitants of her symptoms and previous episodes of depression prior to suggesting listening visits as a treatment. If listening visits are deemed appropriate by the patient and her GP, the practitioner should ensure alternative treatments remain available to the patient.

As with any therapy, women offered listening visits should be informed about what the visits will entail by both the referrer and therapist. During the first listening visit, the therapist should discuss issues around confidentiality and his/her responsibilities towards both the mother and child. These issues will be simpler if the therapist is independent of the woman's GP and PHV, and if he/she is solely delivering care to the woman. With the Government's investment in the Improving Access to Psychological Therapies programme [28], it might be become possible for women to receive listening visits independently of their general practice. In addition, NICE [2] has proposed the development of a multi-disciplinary peri-natal service, and this could provide opportunities for women to receive visits from someone dedicated to them, rather than having responsibility to both mother and baby. Therapists providing listening visits should emphasise that the visits are for the mother to discuss her own concerns and should encourage women receiving this treatment to develop other forms of support that can be utilised once the visits have finished.

I confirm all patient/personal identifiers have been removed or disguised so the patient/person(s) described are not identifiable and cannot be identified through the details of the story.

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