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## **‘Putting on the Mask’: A Critical Exploration of Post-Natal Depression Support Services**

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### **Abstract**

This research explores the experiences of support services for mothers with post-natal depression in Cork (Murphy and Skinner, 2013). The research from which these findings emerge was a collaborative, qualitative study based on interviews with mothers who have or had post-natal depression (PND) and professional support service providers. The aims of the research were to identify what supports mothers with PND had access to, both professional and social, and to assess their benefits. These findings make a distinctive contribution to research on how PND support services are experienced by mothers in Cork, revealing dissonance between the supports provided and those desired by the service users.

**Keywords:** Post-natal depression; mental health; support services; risk.

### **Introduction**

Post Natal Depression (PND) is a condition which affects one in five mothers in Ireland (Cronin, 2012). Bates (1999) describes the characteristics of depression as changes in thoughts, feelings and behaviour, including psychological suffering and a diminished sense of wellbeing, affecting sleep, appetite and energy levels. These characteristics are also present in PND in tandem with a change in routine and thoughts of inadequacy in the early stages of parenting (Howe, 1999). PND covers a

spectrum of levels, ranging from mild to a severely debilitating state. Among the factors which contribute to the development of PND are, birth experience, biological factors, personal history, images of motherhood, lifestyle changes, relationships and recent life events (Brown and Harris 1978, Bates 1999, HSE 2008, Brooker and Repper 2009, Ussher, 2011, Aware 2011). It is, however, a condition that does not discriminate (Kealy and Fogarty 2010, Clark and Fenichel 2001). It affects women from all walks of life, regardless of it being a first or subsequent birth. The difficulty with defining PND is due to the myriad symptoms, causes and effects this condition has on each mother. What can be stated is that the experience of PND is unique to each mother. A common theme among definitions is a depressed mood which lasts, wherein positive thoughts and feelings of joy are supplanted with negative feelings (Etchegoyen, 2000).

### **Rationale and Methodology of the Research**

Both researchers have an enduring interest in mental health issues, having completed work placements in service provision, one in adult mental health and one in child and adolescent services. The authors focused on PND as a dissertation topic because of the dearth of relevant research in this area. Thus far findings from this research (Murphy and Skinner 2013) have been disseminated and presented at five conferences. The researchers also facilitated a workshop during the *Critical Voices Network of Ireland* Conference in 2013. Both have addressed professionals and BSW students, seeking to represent the lived experiences of mothers within PND support services. The findings were also presented to PND Ireland and were well received by the participants and other members. The research was conducted as a component of the Bachelor of Social Work (BSW) degree in association with Community Academic Research Links (CARL). CARL is an initiative in UCC which assists Civil Society Organisations' (CSO) with research they wish to execute. After consideration of topic outlines, the researchers decided to explore PND support services, leading to the final report, *An Exploration of the Experience of Post-Natal Depression Support Services in Cork*.

The researchers employed a qualitative approach. As Sarantakos (2005) states, qualitative research allows an interpretation and facilitates an understanding of people's lives and reality as experienced and perceived by themselves. It also

allowed this research to be flexible, reactive and to retrieve relevant information (Alston and Bowles 2003). An interpretative framework was chosen as it allows an examination of the meaning people attach to their experiences. The researchers interpreted this phenomenon rather than measuring availability and uptake of support services or compiling a support service directory, as each mother's experience of support services was unique (Dennis and Creedy, 2004). A feminist approach in tandem with interpretivism allowed a more in-depth study. Such an approach orbits around the need to comprehend the shared experiences of women about discrepancies in the way things are and the way they would like them to be (Freedman, 2001). As Orme (2009: 71) puts it: 'Feminist theories are fundamental in highlighting the oppressive conditions of women and the ways in which social work can exacerbate or alleviate them'. Grounded theory was employed allowing data collection and analysis simultaneously (Glaser and Strauss, 1967), and enabled the authors to 'develop a theory about the person, events or things under study' (Mark, 1996:215).

Due to the sensitive nature of the research topic, personal interviews with mothers had to be conducted on days when they could avail of support, if required. The interviews occurred in the mothers' homes and they were contacted afterwards to ensure they were comfortable with what was discussed. As this was a participatory research project in partnership with PND Ireland, the chairperson linked us with willing participants. However, to avoid potential bias we sourced three participants who are not members of PND Ireland support group. Nine mothers participated in the research, six from PND Ireland and three non-members. Interviews were taped, transcribed and coded to allow common themes to emerge. This approach to analysis diminished the researchers' personal perception from overly influencing the findings. The data generated was triangulated with the data from interviews with key professionals and findings from the literature review, thereby reducing bias and increasing the validity of the research.

Among the ethical considerations of conducting this research was the emotional turmoil of discussing the experience of PND. We ameliorated these by ensuring the participants were cognisant of the nature of the research and were giving informed, considered consent to participate, free from coercion. We assured the participants of confidentiality and anonymity, especially when writing the final report.

### **Mental Health Services for PND**

There is a large body of literature on the social construction of women's mental health issues. A common theme which emerged was the dissonance between how mothers wanted to live and their lived reality. Ussher (2011: 168) elaborates that 'the contrast between the reality of the demands of the mothering role and idealised constructions of motherhood has been recognised by many feminists to be a cause for depression for women'. White (1996) takes a historical look at the evolution of maternal depression and how it evolved into a medical construct by the dominant and 'knowledgeable' classes. White (1996) states women who did not conform to the notion of femininity, or were deemed wanton or distressed women, or indeed those who challenged the dominant paradigm, were labelled 'mad' women. They were hospitalised, institutionalised or subject to surveillance, in order to protect society from the risk they posed. This 'knowledge' has led to a tendency within mental health services for PND, to address the symptoms: the 'what' rather than the 'why'.

Becoming a mother can be exciting and wonderful. It can also be difficult and challenging, especially for mothers with PND, which can impact on the infant's development. Emotional development begins during pregnancy and continues rapidly for the first two years. Stress has a negative impact on the emotional and social development of an infant. Gerhardt (2004), states that babies are born with a brain which requires them to be socialised into their position in society by their primary care giver. When a baby is tended by a sad, confused, deflated mother this is what the baby internalizes as reality and as Gerhardt (2004: 123) notes, 'children of depressed parents have about a six times greater risk of succumbing to depression themselves'. Social policy provision for PND is limited in Ireland. In 2006 *A Vision for Change* was adopted as policy for provision of mental health services, which aimed to deliver supports and interventions that promote positive mental health within a recovery approach. Reference is made in the document to perinatal psychiatry. In 15.5.4 a recommendation is made that 'one additional psychiatric nurse and a senior nurse with perinatal expertise, should be appointed to act as a resource nationally in the provision of care to women with severe perinatal mental health problems' (Department of Health and Children, 2006). The three main areas of perinatal mental health in clinical focus are depression, schizophrenia and bipolar disorder. While

depression is referred to, it concentrates on the most severe cases with little or no focus on PND.

**‘You are beginning a magical journey’<sup>36</sup>: Analysis of Findings on Mothers’ Experiences**

The nine mothers interviewed stated the ante-natal care received was adequate preparation for childbirth and caring for their baby, but received no information about PND. As one participant put it, ‘They literally throw you a leaflet and tell you have a read of it’ (Participant 3). All agreed that having a one to one conversation about the risks, symptoms and treatments at ante-natal visits or prior to discharge would be beneficial. Additional stressors in the ante and postnatal periods were reported by seven mothers. These include unemployment, bankruptcy, house move, house extension and starting a new business. All nine mothers said they did not know what was happening to them. Eight out of the nine had difficulty sleeping and went to GPs. They were prescribed sleeping tablets.

I hated the sound of birds; it used to remind me that yet again it was another night without sleep. (Participant 1)

Commonly, they did not discuss their feelings with their GP as they felt ashamed, scared, confused:

Couldn’t eat, couldn’t sit, couldn’t talk, racing negative thoughts. I thought I was losing my mind. (Participant 9)

As the time progressed the symptoms worsened. All of the mothers spoke of a struggle for months to maintain a ‘normal’ family life.

You don’t want to go to someone and say ‘I’m a shit mother’. (Participant 2)

All mothers talked of coping mechanisms and trying to disguise how they were feeling. Walking was a common theme to disguise restlessness and racing negative

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<sup>36</sup> Cork University Maternity Hospital (2012). *Maternity: The Ultimate Pregnancy Guide 2012/2013*

thoughts. Hiding symptoms from others was a way of coping and not saying out loud that they were struggling. 'Pretending' and 'putting on a mask' were commonly used phrases among all mothers:

You can hide anything; you can feel like your life is falling apart at the seams and that you can't live another hour, but you can hide it. (Participant 8)

Every hour is like a day, every day is like a week. I stopped wearing a watch, I still don't wear one. (Participant 7)

Some of the literature reviewed suggests that motherhood can be conceptualised by society as a natural and beautiful experience, even though for a large number of mothers it is not. (Bates 1999, HSE 2008, Brooker and Repper 2009, Ussher, 2011, Aware 2011)

Here was my longed for baby and I was cracking up. (Participant 3)

The mothers interviewed felt threatened by this imagery. Some of the mothers said they had supportive husbands/partners:

He was amazing. (Participant 1)

I am convinced I would have ended up in a psychiatric unit only for him. He spent hours talking me down from the day. (Participant 7)

Others spoke of relationship difficulties,

He was useless, ready to walk out after six weeks. (Participant 6)

Regardless of whether or not they were supportive, all mothers suggested that men need supports in their own rights for PND. They agreed that education for men about PND and having someone to talk to would be of huge benefit to partners.

Whatever I went through it was a hundred times worse for him; he had no one to talk to. (Participant 1)

Lack of emotional support from their mothers or mothers-in-law was identified by all mothers interviewed. Only two had emotional support from their own mother. Others' had practical support, yet it was emotional availability they felt they needed more.

She wouldn't be very great to talk about it but she took off the pressure by minding the kids. (Participant 9)

The comfort of her, her smell, getting into bed with her, reassured me. She would tell me wait till Sunday, you'll feel better. It would come and then I'd say, she's right, I feel a bit better. (Participant 1)

At the point of seeking professional help, eight out of the nine mothers were prescribed anti-depressants with differing outcomes. There were benefits for some at a certain point and for others it was a very negative experience. A common theme for other mothers' is exemplified by this statement,

After 4 months I was level, I wasn't down but I wasn't up either I was kind of flat, numb. (Participant 3)

The psychiatrist recommended taking additional medication to 'enhance my moods'. While medication is one option, there was no proposed alternative at the time of approaching a professional for help. At this desperate stage in their PND the mothers took what was offered in an attempt to feel 'normal'.

The good side of anti-depressants isn't talked about, they stopped the racing thoughts. I could sleep. (Participant 4)

I thought I'd be on them for life. (Participant 8)

The cure was worse than the cause. I sat on the side of my bed and couldn't move with the panic attacks, they were worse than the PND. (Participant 2)

Recovery for all of the mothers is a journey which is on-going, some days are good and some are bad. They spoke movingly of being at different stages in their recoveries.

I used to say nothing good can come out of this. But it does, when you get up and it's sunny, you take a deep breath and think I'm well and you appreciate life.  
(Participant 1)

Reflecting on their lowest point to where they are today was a common theme for each of the mothers. For some this is a strength that keeps them positive but all mothers agreed that PND or the fear of developing depression never really goes away. One mother, pregnant at the time of interview said,

I'm pregnant so I cry easily. Why does everyone think it's PND coming back?  
(Participant 8)

On the recovery journey for all mothers, support is a significant factor. Some found the peer support from PND Ireland invaluable. An immediate response to attending was 'knowing I'm not alone' (Participant 9).

There was a mixed response from the mothers' interviewed about their experience of PND Ireland support group. The six mothers' interviewed who are members spoke positively about their experience. PND Ireland runs a monthly support group in CUMH, a coffee morning in a shopping centre and an internet chat room.

I found the chat line was a lifesaver because I couldn't face a group. It's an amazing service, having women there with the same symptoms is a lifesaver.  
(Participant 3)

It was a weight off my shoulders, I'm not mad, I'm not going crazy, other mothers are here looking for help and they are on the medication too.  
(Participant 5)

However, for one mother interviewed, she experienced attendance at the support group negatively.

It's not suitable for everyone, I found it very negative: I went in positive and came out thinking I would top myself. I was told I would never recover and to take the medication. (Participant 4)

Whilst some of the mothers in the support group gained great benefit and attended for years, others cannot envisage being long-term members. It was expressed by some of the members of PND Ireland that they find it difficult to attend meetings now that they are in recovery, as it is difficult to be around the negativity.

It's hard to sit there and hear the distress; you kind of soak it up. .  
(Participant 3)

### **Provision of Support Services for Mothers**

This section outlines, in brief, findings from the perspective of a range of health professionals on their role in supporting mothers and mothers' own perspectives on and experiences of accessing these support services.

#### *A General Practitioner's Perspective*

The General Practitioner (GP) interviewed described how assessing whether a mother has PND is based on prior knowledge and a relationship built over time.

I get to know families intimately. When doing the routines things for baby, one of the main things which women never think about is that I am observing them  
(GP)

This GP identified the struggles for mothers with PND as anxiety, confusion and difficulty talking to their partner: '70% of cases involve stress between partners, explanations turn into arguments'. Prescribing medication in tandem with referrals to PND Ireland or for counselling is the preferred treatment for this GP.

*Mothers' Experiences of their GPs*

He (the GP) was brilliant, eventually (Participant 3).

A shared concern among the mother's was GPs persistently failing to recognise or discuss PND. When PND was eventually diagnosed all but one mother was prescribed anti-depressants without an explanation of possible side effects.

I wished I had cancer, because I would have had my mind to fight it. There's nowhere to go, there's nothing to help you when you don't know what is wrong. (Participant 5)

*A Public Health Nurse Perspective*

Mums are very important to babies and babies are very important to mums, even though things may be stressful. (Public Health Nurse)

Public Health Nurses visit mothers within twenty four hours of receiving a birth notification.

Obviously the physical needs are discussed but we take a holistic approach, looking at the child, their mum and the family unit, and also the supports around them in the community. (Public Health Nurse)

Relationship-building, especially during the initial visit, and allowing a mother to discuss her needs and concerns are encouraged. The Public Health Nurse is in contact with mothers at regular intervals, monitoring a baby's development. They also observe mothers and assess how they are coping within their parenting role. In discussing support services available, the geographical location assumed importance. Some communities in Cork have been classified as Revitalising Areas through Planning, Investment and Development (RAPID) areas, therefore

It depends on where you are which determines what is available. It can be difficult if you live in a different area. (Public Health Nurse)

Mothers with PND living in RAPID areas have access to services not available elsewhere and

areas which might not be deemed as socially disadvantaged can be disadvantaged because they don't have a lot of these services. (Public Health Nurse)

*Mothers' Experiences of Public Health Nurse Services*

I would have liked to talk to her but she was busy. (Participant 9)

Most of the mothers expressed reservations about sharing their feelings or admitting they were experiencing difficulties to their Public Health Nurse. Only one of the nine mothers interviewed experienced a positive support service from her Public Health Nurse. Another told her Public Health Nurse about her PND. This Public Health Nurse subsequently visited for a child development check.

She knew how badly I was suffering and all she talked about was the baby not crawling on her knees. If the baby didn't start crawling she would be referred to a specialist. I blamed the PND for her not crawling. It was another crutch to beat myself with. (Participant 4)

This focus by the Public Health Nurse on child development rather than the mother or the mother-child relationship constructed PND as a risk factor within this distressed mother's mind.

If she had asked me straight out I probably would have lied. I didn't want to seem like I was failing. (Participant 1)

If a mother with PND is 'hyper' this is perceived as a risk. Conversely if a mother is inactive this is perceived as risky. If a baby is too clingy or too distant both are risks perceived to be associated with PND by some professionals. It could thus be summarised as every action or inaction of a mother and a baby may be interpreted as

risky behaviour when PND is internalised by professionals as a ‘risk’. The Edinburgh Scale is a tool used by Public Health Nurses’ to assess whether a mother is experiencing PND. The higher the score: the greater the likelihood that a mother may have PND. One mother reported

I did that questionnaire and I scored 10 out of 12. She should have been calling someone for me, instead she put it in a folder and that was that. (Participant 7)

#### *A Community Support Worker’s Perspective*

Working with the mother, the family and using the community to enhance resilience. (Family support worker)

This community-based support service is located in a RAPID area of Cork. The worker identified the needs of some of the mothers with PND in this area as isolation, deprivation, lack of education, single parenthood and with little or no family or friends for support. This service provides a counselling psychotherapist and a play therapist to mothers with PND to assist with attachment or relationship issues. They also provide affordable Cognitive Behavioural Therapy (CBT) or counselling. Mothers with PND are encouraged to join relevant support groups based in the community.

#### *Mothers’ experiences of Community Support Services*

Services, what services? (Participant 6)

Two of the mothers with PND lived in a RAPID area where this service is available. Neither accessed it. One mother did have access to the crisis multi-disciplinary team consisting of a psychiatrist, a mental health nurse and a social worker. The team returned for a further two weeks when she experienced panic attacks as a side effect of her medication.

They were brilliant. They could see how I was really coping because I couldn’t hide anything when I was in my home. (Participant 8)

Subsequent to this intervention this mother was linked into affordable CBT and a stress management course which she found helpful.

*An Infant Mental Health Specialist's perspective*

What helps a mind to grow is the sense of being known. (Infant Mental Health Specialist)

PND can have a devastating effect on some mothers, but also impacts on the relationship between a mother and baby. The presence of other supports within a family serves to diminish the effect of PND on a baby. Sometimes, however, a rupture can occur in the relationship between mother and baby, requiring some form of intervention. Otherwise,

you might get the mother over the depression but you haven't helped the relationship. (Infant Mental Health Specialist)

PND can affect a mother's ability to provide sensitive, responsive parenting, resulting in emotional, developmental and behavioural difficulties in later years. However, targeted interventions during the 0-3 years can help to repair the schism in the mother/infant dyad.

*Mothers' perspectives on infant-mother relationships*

Time and time again the mothers spoke about their concerns for their babies and their experiences of the caring relationship:

All the nights standing over her cot looking at her and the guilt. (Participant 6)

I don't remember his first year. I got him christened again, just us, because I can't remember it. I never interacted with him. I never had the love until eight months. (Participant 1)

One mother's partner constantly asked

'Do you love him? Oh God, say you love him'. (Participant 9)

Another wondered about the impact her PND had on her child as she has researched this and finds it extremely painful to consider. Other mothers did not feel PND had any impact on the baby.

It did not affect him; he is a really good child and never cries. (Participant 1)

### *A Midwife's Perspective*

The midwife interviewed described her role as 'caring for the mother and the baby's physical and medical needs only'. The midwife looks after pregnant women for the duration of their pregnancy. She does not discuss PND with mothers. Her role is to prepare pregnant women for labour and offer post-natal advice in how to care for baby and meet the baby's physical needs.

### **Summary of Findings**

Each mother interviewed had knowledge about PND, but could not envision that it could happen to them. Why? The majority of the mothers interviewed are what their partners, family, friends and support service providers describe as successful, intelligent women. Most had careers, were home owners, attractive and capable women in outwardly loving, stable relationships. The mothers themselves described the 'type' of mother they originally perceived would experience PND. They described depressed single mothers with little family support who failed to bond with baby.

Most mothers interviewed had experienced difficulty in accessing support services, especially from GPs and Public Health Nurses. When a GP knows this capable person it is easier to miss the symptoms of PND. All of the mothers described 'putting on a mask', disguising their symptoms because of shame, fear of being judged bad mothers or fear of being perceived as a risk to their baby.

Every mother interviewed had experienced a lack of emotional availability from their own mothers or mothers-in-law, causing them to disguise their feelings. What became apparent from this study was the impact of the birth experience, other life stressors, and the propensity for social comparison, which caused great distress for the mothers interviewed. However, all of these mothers spoke positively about embracing a recovery approach to overcome their PND.

Recommendations arising from the study include a desire for PND symptoms and support services be discussed at ante-natal clinics, ante-natal classes and prior to discharge from the CUMH. The mothers also want relevant information and training provided for GPs, Public Health Nurses and other professionals. The construction of PND as a risk to child development diminishes the effectiveness of the service provided by Public Health Nurses and others, causing mothers to put on a mask, disguising their symptoms rather than engaging in meaningful interventions. Not one of the mothers interviewed had ever provided feedback to service providers about the effectiveness of their intervention. This is a valuable untapped resource which could enhance service provision. All of the mothers wanted affordable cognitive behavioural therapy, psychology, counselling and community mental health services available to all, regardless of geographical location.

The six mothers who were members of PND Ireland had recommendations specific to this support service. They wanted weekly rather than monthly meetings and coffee mornings. They wanted meetings to focus on providing support, rather than discussing fundraising, media campaigns and other issues. Some want to develop a stronger focus on recovery and positive coping skills, rather than become mired in negativity which increased feelings of despair and anxiety. They also wished to enact group facilitation skills allowing members present equal time to discuss issues of concern. Some mothers' are willing to become occasional group facilitators with appropriate training. Others, once they achieve confidence in their recovery from PND, envisage leaving the group. Some members had to travel long distances and expressed interest in setting up a support group locally. They also wished to explore the possibility of creating a dedicated men's' support group. Every member expressed a desire to relocate the service from its obscure location at the rear of the CUH campus and embed it within the maternity unit, thereby raising awareness about PND and supports available.

## **Conclusion**

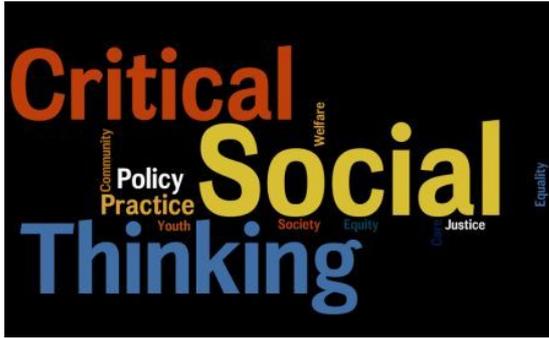
We set out to gain an understanding of the experience of PND support services for mothers in Cork. In doing so, we questioned why services were experienced in this manner? What this exploratory research revealed is the discriminatory manner of some support service provision. These are located in specific geographical locations

or attached to psychiatric services. The services available to all mothers, GPs and Public Health Nurses were perceived by most of the mothers interviewed as unhelpful to them personally, due to their implicit sense of being judged and assessed. Some of the mothers interviewed benefited greatly from the PND Ireland support group. Other women, friends, work colleagues, relatives, caused real pain by not understanding how PND affects a mother. Telling a depressed mother to ‘snap out of it’ serves to increase feelings of guilt and anxiety and leads mothers with PND to seek isolation or to pretend, when what they say would really help is a full and frank discussion about feelings. There are many issues highlighted within this report which would benefit from further research and add to this initial exploratory study, in order to create support services which would serve the needs of mothers with PND. One in five mothers experience PND. This is a large minority which demands a cohesive, effective response from policy makers, service providers, communities and families to enhance the lives of these mothers and babies.

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## **Exploring the Experiences of Families of Children Diagnosed with Autism Spectrum Disorder**

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### **Abstract**

The purpose of this piece of research is to explore the experiences of families of children diagnosed with Autism Spectrum Disorder. This research examines the effects of having an autistic child in the family and identifies the coping strategies that parents adopt on a daily basis, looking particularly at the social, emotional and financial impacts on family life. Assessing the supports and services in place to assist these families and children to live a better life is a key aspect of this research. The research draws on interview data with female carers of children with autism. It finds that carers experience social isolation and financial stress, which is exacerbated by socio-economic circumstances, evidencing an emergent two-tier level of access to resources and support services.

**Keywords:** Autism; support services; coping mechanisms.

### **Introduction**

This research on which this article is based focuses on four main research questions. First, it explores a short history of the discovery and diagnosis of autism. Second, it reviews policy-making and service provision for children with autism and their families in the Irish context. Third, it examines, through qualitative primary research the different effects of having a child with autism on families. Fourth, it identifies the