

**THE EXPERIENCE OF POSTPARTUM DEPRESSION:
A GROUNDED THEORY STUDY**

By

Michal Regev

B.A., Tel-Aviv University, 1991
M.A., The University of British Columbia, 1995

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

In

THE FACULTY OF GRADUATE STUDIES

Department of Educational and Counselling Psychology
And Special Education

We accept this thesis as conforming
to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA

June 28th, 2001

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Department of Counselling & Educational psychology & Special Education
The University of British Columbia
Vancouver, Canada

Date July 20th, 2001

Abstract

The purpose of this study was to explore the experience of postpartum depression and to generate a substantive theory that would describe and explain this experience. Although the area of postpartum depression has been extensively researched in the past three decades the overwhelming majority of studies have employed quantitative research methods. These methods do not illuminate the experience from the women's point of view and they disregard the context within which the experience occurs. This study employed the Grounded Theory Method, a naturalistic-inductive method of inquiry, that allowed for the participants' experience to be described and for a substantive theory to emerge, which is grounded in the data.

Sixteen women (age range 27 to 42 years) were interviewed twice about their experience of depression following childbirth. The first interview focused on the women's experience of depression, while the second interview centred on the women's comments and suggestions regarding the researcher's thematic summaries of their interviews. A semi-structured interview guide was used during both interviews, which allowed for variations to emerge while a unified framework was maintained.

The grounded theory analysis of the data led to the development of a substantive theory describing and explaining the social-psychological process of the experience of postpartum depression. The theoretical model that describes and explains the experience has six phases: (1) Becoming Lost, (2) Getting Trapped, (3) Deep in Depression, (4) Struggling to Break Out, (5) Breaking out, and (6) Staying Well. In addition, two recurrent themes were identified: (a) The Relationship with the Partner, and (b) A Redefined Self. The theoretical model illustrates the relationship among the different

phases, as well as the properties that make the phases up. It also describes the types, circumstances and conditions under which the experience occurs. Most of the components of the theoretical model are supported by the literature on postpartum depression. However, the model adds to the literature in identifying specific parts of the process of postpartum depression such as the period leading to the onset of depression, the struggle to come out of the depression and women's agency in coming out of the depression and maintaining their wellness following recovery. As well, the study illuminated the changes in the relationship with the partner, and the process of redefining self through the experience of PPD.

Finally, the implications for further research and practice that stem from the theoretical model that was developed are discussed.

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Acknowledgements

I feel indebted to many people who assisted me in different ways during the time of this long, exciting, challenging and sometimes overwhelming project. I am deeply and sincerely grateful to my dissertation committee. Specifically, to Dr. Bill Borgen, whose guidance, encouragement, availability and wisdom have been invaluable. Also, for his careful editorial assistance with the manuscript and insightful comments. Dr. Borgen has been my academic mentor and has offered me continual support during this project and throughout my Ph.D. program; To Dr. Garry Grams, who guided me through the “thick woods” of the Grounded Theory Method with patience, humor, generosity and encouragement. Dr. Grams worked very closely with me throughout this research project and has devoted a lot of time and effort guiding me through the different stages of the study, reading and re-reading the manuscript and providing helpful comments, questions and affirmations. Further, I thank Dr. David Freeman for offering his perspective on the phenomenon of postpartum depression and for providing me with feedback and useful comments.

I would like to acknowledge my family who has been very supportive of my academic career over the years. Specifically, my husband, Rafi, who has carried the financial burden throughout the long years of my graduate studies and who has supported me in many ways. It is thanks to his perseverance and continuous support that I was able to complete my studies.

To my children, Rotem, Saar and Or, whose love and encouragement have given me the strength to carry on and who have helped me to put things in perspective and remember the truly important things in life. To my son-in-law, Shay, who is like a son to

me, for his support and assistance with the graphic design of the theoretical model. Many thanks to my parents, Shula and Zvika Gottlieb who live in my homeland Israel, for loving, supporting and helping me from afar; for allowing me to fly away while keeping the “nest” warm and open for me to visit. I am also thankful to my sister Efrat and my brother Alon who have shown me nothing but love and support over the years.

Finally, my sincere gratitude goes to the women who shared their stories and experiences of postpartum depression with me. The participants’ willingness to cooperate, their openness and their courage to go back to painful experiences made this project possible.

In gratitude, Michal

Dedication

To my beloved parents, Shula and Zvika Gottlieb, who have provided me with a Secure Base and a Safe Haven and who have taught me the most important things I know.

Positive attachments create a **Secure Base** from which individuals can operate and respond to their environments in the most adaptive way. Positive attachments also create a **Safe Haven**, which provides an optimal context for the continuing development of the adult personality.

John Bowlby

CHAPTER I

INTRODUCTION

Personal Perspective

No person and therefore, no researcher, can be totally unbiased (Creswell, 1998; Lincoln & Guba, 1985; Strauss & Corbin, 1998). Therefore, it is expected that researchers are aware of their biases and of the personal reasons that brought them to study a certain phenomenon or area. As well, researchers are expected to make their biases and assumptions known to the reader in order for the readers to be able to relate to the researcher's interpretations in light of these biases. I shall therefore begin by describing that part of my personal background that is related to the problem area of this study, namely, my experience of depression following childbirth.

I was twenty-one when I gave birth to my first child, Rotem, who was a healthy, sweet and charming baby-girl. My pregnancy and delivery were problem-free. However, soon after the birth, I realized that the reality of having a baby was totally different from what I had expected it to be. The baby was restless, and very difficult to soothe. She did not sleep more than one hour at a time, and cried a lot. When I consulted my mother about my baby's behavior she said that her experience with me was very similar and that it was "a matter of temperament". Thus, a few days after I got home from the hospital, happy and proud of myself, I began realizing that my life had been changed dramatically and irreversibly. Even worse, I felt that my life as I knew it had been taken away from me forever.

Ongoing problems with breastfeeding and continuous sleep deprivation made me feel more and more irritable and depressed. I was angry with people who I knew for not

warning me or preparing me for this time of upheaval. I felt angry with my daughter for taking my freedom and my sleep away from me, and then I felt angry with myself for having those negative feelings. After all, I said to myself, she is not to blame; she did not choose to be my child. I started developing a negative self-image as a mother. "What kind of a mother feels such negative feelings toward her helpless little baby?" I reproached myself over and over again, and yet, I could not help but having those feelings. Worst of all, I believed that my situation and these feelings were going to last forever.

I was too proud and too ashamed of myself to tell anyone about how I felt. I believed that people were going to scold me, or at least, develop a very negative opinion of me if I did. Several weeks went by and my mood worsened. Still, I did not confide in anybody. However, one day I felt so depressed that I decided to seek help at the local mental health centre. With mixed feelings of shame and relief, I told the psychologist my story. After listening to me for an hour, the psychologist concluded that my story represented "a normal case of adjustment to motherhood". She advised me to go home and focus on my baby. "With time", she said, "you are going to feel better." I went home feeling worse than ever. "If this is nothing special, then how come I feel so down?" I asked myself. My conclusion was that there was something really wrong with me and that I absolutely should not feel the way I did. These thoughts, though, did not help to alleviate my depression.

Months went by, and my baby was having a more manageable routine. I started sleeping better, and had a better sense of control over my life. I was also becoming more and more attached to Rotem, and I started experiencing moments of joy taking care of

her. When I went back to work, I felt that my life was not so bad after all, and that things were becoming more manageable and less chaotic. Time was indeed a healer, but the road to healing was rough and lonely.

Since the birth of my first child, I have had two other children. Luckily, the depression did not come back. However, I noticed that some of my relatives and friends have had a similar experience to the one I had with my first born. They were overwhelmed by the changes in their lives, and by the amount of energy, patience and sacrifice that were involved in raising a child. Three of my acquaintances got severely depressed and two had to be hospitalized. They were all eventually diagnosed as having postpartum depression, and were given treatment accordingly. All three of them are currently healthy and fully functioning, but remember the first year following the birth of their children as the worst in their lives.

When I started working on my Masters thesis in counselling psychology, I decided to explore first time mothers' expectations and experiences of motherhood. I was interested in other women's experience and how it related to my own. As a counsellor, I was also interested in ways to help new mothers in therapy. I conducted in-depth interviews with twelve women, a few weeks before, and a few weeks after their first birth. The results of my study have been outlined in detail in my Masters' thesis. The one finding that stood out for me, however, was that of the twelve women, five have become somewhat depressed, and one has become severely depressed and was hospitalized. This made me more interested in the phenomenon of postpartum depression, and I decided to focus on this issue both in the framework of my pre-doctoral internship, and in my

dissertation. I am specifically interested in the experience of PPD from the point of view of the mothers and in the context within which postpartum depression happens.

The Problem

Motherhood is a common, normative experience in the lives of most women. In western societies, motherhood has been referred to as the most satisfying and fulfilling experience that a woman can have (Beck, 1993; Crouch & Manderson, 1993; Thurer, 1994). Indeed, the birth of a baby is usually perceived to be a joyful occasion, and the mother is expected to feel happy and fulfilled. Yet motherhood may sometimes pose a threat to women's physical and/or mental health. Research indicates that between 10-16% of recently delivered women become so depressed that their daily functioning is seriously impaired and their sense of well-being is greatly impeded. When these women seek professional help, they are often diagnosed as having *postpartum* or *postnatal depression* (Brockington, 1996; Cox, 1986; Kendall-Tackett, 1993).

Postpartum depression is an umbrella term for emotional disturbances following childbirth. Three major types of postpartum depression have been identified (Brockington & Kumar, 1983; Cox, 1986; Kendall-Tackett, 1993). The *maternity blues*, which is the mildest and most transient one, *puerperal psychosis*, which is the most serious, and *chronic or major depressive syndrome*, which is most often referred to as postpartum depression (PPD).

Postpartum depression affects women of all ages, religions, levels of education and socio-economic status in western societies (Cox, 1986; O'Hara, 1995). When a woman has postpartum depression her daily functioning is often impaired and she may be

extremely despondent. This may affect not only the woman but also her immediate family. It is therefore of utmost importance to study this phenomenon.

Rationale for the Study

During the past three decades there has been a voluminous number of studies in the area of postpartum depression. Quantitative studies have linked postpartum depression to a vast array of variables such as prenatal depression, hormone level, baby temperament and maternal personality traits (for a thorough meta-analysis see Beck, 1996a). Some of the studies suffer from serious methodological problems as discussed in chapter two of this paper. Also, as was observed by Brockington (1996) there has not yet been published a study that explored the relative contribution of each of the identified associated variables to the phenomenon. Finally, the overwhelming majority of studies have employed research methods that examined the relationship of specific variables with PPD. Only a small number of studies have utilized qualitative research methods that enable the exploration of the experience of postpartum depression from the point of view of the women who have had it (e.g., Beck, 1992, 1993; Mauthner, 1999; Nicolson, 1999). Also, women who experience postpartum depression have often been studied as having the problem within them, while the contexts within which they live and function have been mostly ignored (Beck, 1993; Mauthner, 1999; Stoppard, 1999; Stoppard & McMullen, 1999). The relationships of these women with partners, members of the extended family and other members in the community are absent from relevant research. However, women in general and women who experience postpartum depression in particular, do not exist in isolation. Rather, they are impacted by and have an impact themselves on the systems they belong to, such as families and communities. Hence, the

experience of postpartum depression needs to be explored within its context and not as an isolated phenomenon.

A few studies have begun to explore PPD in a more holistic way, and have started to shed some light on previously unexplored parts of the experience (e.g., Beck, 1992, 1993; Mauthner, 1999; Nicolson, 1999). Beck (1993) has also started the development of a substantive theory of postpartum depression. However, much more qualitative research is needed to address issues related to the experience of postpartum depression, like the process women undergo when they become depressed, the context within which these women become depressed and the relationships between the women and their significant others.

Purpose of the Study

The purpose of this study was twofold. First, the study was designed to explore the experiences of women who have had postpartum depression from their point of view, by listening to their descriptions of the experience. Second, the study aimed to further the development of a substantive theory that would explain the structure of postpartum depression in its context (Glaser & Strauss, 1967; Strauss & Corbin, 1998).

Research Questions

It is common practice in qualitative research methods to begin the study with broad and general questions in order to allow for flexibility and openness to a variety of themes (Lincoln & Guba, 1985). It is recommended that the questions that guide the study are “open-ended, flexible, and broad to begin with and then become more focused and refined as analysis occurs” (Rafuls & Moon, 1996, p. 68). Accordingly, the following research questions initially guided the investigation:

1. What is the lived experience of women who have had postpartum depression and who have come out of it?
2. What are the psychological and social factors that play a role in a woman's experience of postpartum depression?
3. What is the structure of the experience of postpartum depression?

Answering these questions illuminates the experience of women who have postpartum depression, and helps us understand how these women perceive their experience and how it affects them. It also helps us understand the elements that play a role in this phenomenon from the point of view of the women who experience it. Finally, it helps us to be more aware of the phenomenon and to tailor the help we offer these women to their needs, as they perceive them.

Methodological Approach

The goals of this study were to explore the experience of postpartum depression in its context and to develop a theory that would describe and explain it. Due to the scarcity of qualitative data in this area, discussed previously in this chapter, it was my decision to employ a qualitative research method. Specifically, I chose to use the Grounded Theory Method (Glaser & Strauss, 1967) as the method of inquiry for this study because of its merit in allowing participants experiences to emerge, due to its rigor and because it promotes theory development (Charmaz, 1996; Grams, 1998; Rafuls & Moon, 1996; Strauss & Corbin, 1990, 1998). An overview of the Grounded Theory Method is presented in the methodology chapter.

Overview of the Dissertation

This dissertation has five chapters. The first one is this introduction chapter in which I have attempted to orient the reader to the phenomenon under investigation and to provide a brief rationale for my study. In the second chapter I review the literature in the area of PPD that was available at the starting point of this study, and summarize the information that studies in this area provide as well as their limitations. I also point out to gaps of knowledge in this area. In chapter number three, *Methodology* I discuss in detail the rationale for choosing the Grounded Theory Method (Glaser & Strauss, 1967) for this study. As well, I provide an overview of the method and some definitions of relevant terms. In the third chapter I also describe the procedures used to conduct the study. In the fourth chapter I provide a detailed description of the study findings. In the fifth and final chapter I discuss the findings in light of current literature in the area of PPD as well as the

implications for further research, practice and policy making. The reference list and appendices are found at the end of the dissertation.

CHAPTER II

A REVIEW OF THE LITERATURE ON POSTPARTUM DEPRESSION

Introduction

The literature in this chapter represents the starting point and the background for this investigation. As Strauss and Corbin (1990, 1998) postulate, a researcher needs to embark on a grounded theory project with some knowledge of the area under investigation. However, they caution researchers and advise them not to review new literature that is published while they are conducting their study in order to allow creativity and discovery of new themes and ideas. Accordingly, this chapter includes the literature that I reviewed prior to data collection and analysis. In chapter V, a discussion of relevant literature that has been published recently is presented.

The birth of a child is a common and normative experience in the lives of women. Motherhood has been perceived not only as a common practice, but also as a positive experience that enhances women's sense of fulfillment and happiness (Bergum, 1989; Crouch & Manderson, 1993; Dorr & Friedenber, 1984; Miller, 1999; Thurer, 1994). Nevertheless, motherhood may pose a threat to a woman's physical and mental health. In fact, many women describe the first few years of their children's lives as the most challenging years in their own lives (Crouch & Manderson, 1993; LaRossa & LaRossa, 1981). Most women cope well with the difficulties and challenges of motherhood. Some, however, become so anxious, distressed and/or depressed that they find it hard or even impossible to function. These women are often diagnosed to be suffering from *postpartum depression* (Brockington, 1996; Cox, 1986; Kendall-Tackett, 1993).

Postpartum Depression is a general term referring to emotional disturbances in recently delivered women. Currently three major types of postpartum emotional disturbances are recognized (Brockington and Kumar, 1982; Cox, 1986; Harris, 1994; Kendall-Tackett, 1993). The mildest and most common among these types is the *maternity blues* with onset between the third and sixth day after delivery. The Maternity Blues is manifested through tearfulness, extreme changes in mood, irritability and worrying. It is estimated that between 60%-80% of women experience the Maternity Blues following child birth (Cox, 1986; Kendall-Tackett, 1993). The most severe form of postpartum disturbances and the rarest one is *puerperal psychosis* with incidence of between 0.5% and 1% of recently delivered women. In addition to mood disturbances, Puerperal Psychosis include cognitive distortions. The third type, the *chronic depressive syndrome* or *moderate depressive disorder*, which is often referred to as Postnatal or Postpartum Depression, is more debilitating and prolonged than the Maternity Blues and is characterized by tearfulness, despondency, feelings of inadequacy, guilt, anxiety, irritability and fatigue. Its incidence is currently estimated to be between 10%-16% of recently delivered women (Brockington, 1996; Hall et al., 1996; Kendall-Tackett, 1993; Kruckman & Asmann-Finch, 1986), but some studies that examined disadvantaged populations report PPD incidence of as high as up to 42% (Hall et al., 1996; Hobfoll et al., 1995). The inconsistent estimate of PPD's recurrence percentage is due to the variety of types of surveys conducted. Many women who experience postpartum depression are not included in hospital surveys simply because they are not referred to hospitals (Brockington, 1996; Crouch & Manderson, 1993; Kendall-Tackett, 1993).

Definitions and descriptions of Postpartum Depression (PPD) have been provided by mental health clinicians and researchers alike (Brockington, 1996; Cox, 1986; Kendall-Tackett, 1993; Kruckman & Asmann-Finch, 1986). Interestingly enough, the Diagnostic and Statistical Manual of mental disorders (1994, fourth edition) does not define postpartum depression separately from other types of depression. Depression, mania or psychosis are defined as postpartum disturbances whenever the onset is "within 4 weeks after delivery of a child" (p. 386). The lack of specified definition of postpartum depression in the DSM-IV on the one hand, and the specific definitions offered by some clinicians and researchers on the other hand, reflect an ongoing debate on whether or not PPD is a specific diagnostic concept (Brockington, 1996; Bell et al., 1994; Cooper & Murray, 1995).

A review of the literature pertaining to PPD reveals four major thrusts of research. The first, and the most voluminous, focuses on identifying causes and predictors of Postpartum Depression (Beck, 1996a; Brown & Small, 1997; Fontaine & Jones, 1997; Harris, 1994). The second is aimed at identifying the most effective treatment program for women who experience PPD (Meager & Milgrom, 1996; Stuart & O'Hara, 1995). The third thrust of research focuses on the growing debate between those who perceive PPD to be distinct from other types of depression and those who perceive it to be the same, except that its onset occurs following child-birth (Ballard & Mohan, 1993; Bell & Land, 1995; Cooper & Murray, 1995; Nieland & Roger, 1997). The fourth focuses on the impact that PPD has on infant and child development (Murray & Fiori-Cowley, 1996; Murray & Hipwell, 1996; Sharp & Hale, 1995). Review and critique of the literature pertaining to all four thrusts is beyond the scope of this paper. I shall therefore focus on

the first of these four, namely, causes and predictors of PPD. This area is strongly linked to the field of counselling psychology. Identifying causes and predictors of PPD is of importance to the field of Counselling Psychology because it may enable counsellors to screen women for risk factors. As well, it may help in designing preventative interventions to decrease the recurrence of PPD and provide support for women who experience PPD. Identifying risk factor and possible causes may help counsellors to design effective interventions and prevention programs.

Predictors of PPD

During the past three decades a relatively large number of studies have examined possible correlation between Postpartum Depression and a variety of predictive variables. Beck (1996a) conducted a meta-analysis of 44 relevant studies, which had been published during the period from 1974 to 1994. She found that factors predictive of postpartum depression have been grouped into four categories: obstetrical, physiological, psycho-social, and history of psychiatric disorders in the mother or her family of origin. Beck's (1996a) aim was to determine the magnitude of the relationship between PPD and eight predictor variables as follows: prenatal anxiety, prenatal depression, history of previous depression, maternity blues, social support, life stress, child care stress, and marital satisfaction. She did not analyze studies that focused on physiological predicting variables.

Beck's (1996a) meta-analysis showed that the relationship of prenatal depression and postpartum depression was in the range of a large effect size. The mean r was .51 and the mean r weighted by sample size was .49. The relationship of child-care stress and PPD was in the range of a large effect size (weighted mean r was .48). The relationship

between life stress and PPD can be considered in the range of a moderate effect size (weighted mean r was .40). In the area of social support and PPD there was a moderate r effect size (weighted mean r was .39). The relationship between prenatal anxiety and PPD was found to be in the range of a moderate effect size (mean r ranged from .30 to .36). There was also a moderate effect size where the relationship between maternity blues and postpartum depression was investigated (mean weighted r ranged from .35 to .37). Another moderate effect size was found when the relationship between marital satisfaction and PPD was investigated (mean weighted r ranged from .29 to .37). Finally, an investigation of the relationship between history of previous depression and PPD yielded a medium effect size with mean r ranging from .27 to .29.

Beck (1996a) developed a scoring system to measure the quality of each study in her meta-analysis. The variables included in the scoring system were as follows: first-author expertise, funding for the research, sampling (convenience, matched or random), sample size, the instruments' reliability and validity, PPD measurement (not measured, self report, Research Diagnostic Criteria or a combination of self-report and RDC), research design (stimulated PPD, cross-sectional or longitudinal), data collection, data analysis (descriptive statistics, nonparametric statistics, bivariate statistics or multivariate statistics). The highest possible score in this evaluation was 29 points. For the 44 studies, the range of quality scores was 12 to 24, with a mean of 17. If we translate this result to percentages, the average quality of the 44 studies was less than 60%, which is not very high. Indeed, there were studies that were given 22-24 points, which is around 80%, but there were other studies that received only 12 points, which translates into 40%. That

means that in general, the studies that Beck (1996a) was able to review for her meta-analysis, were not necessarily high quality studies.

Beck's (1996a) meta-analysis provided a comprehensive overview of the findings across studies. However, it also pointed out to the fact that research in this area has been inconclusive and that the search for causes and predictors of PPD needs to continue. We are far from being able to conclude that a certain variable is the cause or may serve as a sole predictor of Postpartum depression.

Biological Predictors of PPD

Due to the numerous physiological changes that occur during the early postpartum period, researchers have investigated possible biological variables that may be the cause of postpartum depression (e.g., Handley et al., 1980; Harris, 1994; Harris et al., 1996; O'Hara et al., 1984). Some evidence was found that links PPD to low levels of cortisol during pregnancy and following childbirth. However, these studies are inconclusive and have some serious methodological problems. For example, Harris et al. (1996) examined the correlation between the levels of progesterone and cortisol¹ in women's saliva, and PPD. Their sample consisted of 120 women of whom 7 became depressed following childbirth. The results showed that there was no significant difference between depressed and non-depressed women in terms of level of progesterone. There was, however, a significant difference ($p=0.024$) between depressed and non-depressed women in terms of level of cortisol. Women who became depressed had lower level of cortisol before and after the delivery than women who did not become depressed. The authors conclude that low level of cortisol during pregnancy and after

¹ Both progesterone and cortisol are hormones that are rhythmically secreted by the Adrenal throughout the day and night (Hole et al., 1996).

childbirth is associated with depressed mood. There are, however, a few questions regarding the design of this study. To begin with, levels of cortisol change rhythmically throughout the day (Hole et al., 1996). The participants in this study “were shown how to collect saliva and were asked to take samples at 0800 and 2200 hours daily...” (p.740). Because the samples were taken by the women themselves without any supervision, we cannot be sure that there was no difference between the two groups in terms of their compliance with the instructions. We may suspect, for example, that women who became depressed were less compliant with the instructions and did not consistently take the samples on time because they were preoccupied with other things and were more forgetful or simply not interested. Also, the authors note that there was 75% compliance rate in terms of the number of samples collected. They do not provide, however, any information about a possible difference between depressed and non-depressed women’s compliance rate. Thus, we cannot tell whether women who were depressed differed in any way from women who were not depressed in terms of compliance and, how this difference may have affected the results of this study. Lastly, only 7 women of the 120 participants became depressed. This may be due to the fact that the authors limited themselves to 5-6 weeks postpartum. It is recognized that some women get depressed at a later stage in the first year postpartum (Beck, 1992; Fleming et al., 1990). In any event, 7 is a very small sample to conduct any kind of statistical analysis on. Therefore, the results of this study are questionable.

Other studies that examined the relationship between physiological variables and PPD have been either inconclusive or insufficient in their ability to define the nature of correlation (Brockington, 1996; Harris et al., 1989; Harris, 1994; Kendall-Tackett, 1993).

For example, Harris et al. (1989) found no differences in levels of estrogen and cortisol between depressed and non-depressed women 6-8 weeks after delivery. Another two studies examined the relationship between PPD and malfunctioning of the thyroid gland (Pop et al., 1991; Harris et al., 1992). The results of both studies indicated that women who have postpartum malfunctioning of the thyroid gland were prone to episodes of PPD. However, not all women who experience PPD have a malfunctioning of the thyroid. In fact, only a small percentage (between 10-15%) of depressed women has that syndrome. For most women who experience PPD, then, there has to be other factors that play a part in their situation.

Personality Characteristics as Predictors of PPD

Two recent studies examined the relationship between personality characteristics such as self-esteem and optimism, and PPD. Fontaine and Jones (1997) predicted that both self-esteem and optimism would be negatively associated with depressive symptoms. They did not predict which of the two variables would be a more salient predictor because of the conceptual overlap between them. The authors used the Life Orientation Test (LOT) to measure dispositional optimism, the Self-Esteem Scale (SES) to measure self-esteem, and the Edinburgh Postnatal Depression Scale (EPDS) to assess postpartum depression during pregnancy and at 2 and 6 weeks postpartum. Correlational and descriptive statistics were used to determine the correlation between self-esteem and PPD as well as between optimism and PPD. They also examined the correlation between prenatal and postnatal scores on the LOT and the SES. Results indicated that both optimism and self-esteem were negatively associated with symptoms of postpartum depression. However, when partial correlation were computed to determine the variables'

independent association to the EPDS score, self esteem was the only independent predictor of lower levels of depressive symptoms both during pregnancy and the postpartum period. The authors conclude that there is a unique component in self-esteem that functions as a buffer against depression. They postulate that this component refers to “the level of confidence in one’s capabilities to produce the desired outcome” (p.62). Fontaine and Jones (1997) suggest that self-esteem is derived from internal causes whereas optimism is derived from external causes because it is an expectation that things will be positive irrespective of the person’s own competencies and behaviors.

While Fontaine and Jones’ (1997) study is interesting, it has a few limitations that weaken it. First, only 45 out of the 100 women who had been approached by the authors agreed to participate in this study, a modest response rate. The authors do not provide enough detail on the way participants were approached nor do they give any explanation, even a speculated one, as to why the majority of them refused to participate. The reader remains in the dark as to the information that would have been obtained from more than half of the original sample.

Another problem with this study is that it does not provide the reader with basic information such as the percentage of women who became depressed either during pregnancy or postpartum. If, for example, only 2 or 3 women were depressed, then the statistical analysis that was used in this study is meaningless. Because the authors do not provide this information, we simply do not know.

Yet another weakness in this study is that it only used one measure to assess depression. The EPDS is a self-report measure for postpartum depression that has been proven to be highly valid and reliable. Nevertheless, the authors of this test highly

recommend the use of a clinical interview and another measure before a diagnosis of PPD is assigned. We therefore cannot be sure that the women who were assigned to the depressed group were actually depressed.

Finally, the design of this study did not allow for an exploration of the ways in which self-esteem and optimism may influence the psychological well being of women in the perinatal period, i.e., during pregnancy and following childbirth. An exploration of this kind may yield some important information about processes that are related to psychological well being of perinatal women.

Hall et al. (1996) examined the role of self-esteem as a mediator of the effects of stressors and social resources on mothers who experience PPD. The authors followed the diathesis-stress model of depression (Beck, 1967; Brown & Harris, 1978). According to this model, a combination of internal vulnerability factors and external stressors produce depression. Hall et al. (1996) hypothesized that external factors such as everyday stressors and life events, poor quality of primary intimate relationship, and a lack of social network ties, would adversely affect self-esteem. In return, low self-esteem would result in high depressive symptoms. Thus, self-esteem was posited to mediate the relationship between external stressors and the outcome of depressive symptoms in postpartum women.

The participants in this study were 738 women who had given birth to a live baby 1 to 2 months prior to participation. Most of them were from North Carolina and others from south Carolina. The majority of the mothers (83%) gave birth to babies that were eligible for the North Carolina's High Priority Infant Program. Criteria for program eligibility included maternal risk factors (e.g., substance abuse, mental illness, and

adolescent pregnancy) and biomedical factors (e.g., congenital anomalies, low birth weight, and neonatal illness). The mean age of the mothers was 21.9 years (SD = 5.4, range 12 to 42). Many of them had an annual income of under \$ 10,000. Sixty eight percent were unemployed, and more than half had not completed high school. Over half of the sample had never married and were African American.

Chronic stressors were measured with the Everyday Stressor Index (ESI), Stressful life events were measured with The Life Experiences Survey (LES), and the quality of the primary intimate relationship was measured with the Autonomy and Relatedness Inventory (ARI). The Berkman Social Network Index was used to measure the quantity of social network ties, and the Rosenberg Self-Esteem Scale was used to measure self worth/self acceptance. Finally, the Center for Epidemiological Studies-Depression Scale (CES-D) was used to measure depressive symptoms of the mothers. The data was analyzed using multiple regression, multiple logistic regression, and path analysis.

The results were that mothers of infants at both social and biomedical risk had a significantly higher mean CES-D score than those with infants at biomedical risk only. Also, lower self-esteem was predicted by lower quality of the primary intimate relationship and higher everyday stressors. Everyday stressors exhibited direct effects on depressive symptoms, as well as indirect effects via self-esteem. However, the direct effect of everyday stressors was stronger which is contrary to the hypothesized model. In addition a strong correlation was identified between self-esteem and depressive symptoms. Specifically, mothers with a self-esteem score of 20 were three times more

likely to have high depressive symptoms than those with a score of 25, and mothers whose self-esteem score was 15 were 11 times more likely to have high CES-D scores.

The authors conclude that the findings support the modified vulnerability-stress model of depression, “a model in which self-esteem mediated the effects of chronic stressors and intimate relationship quality on depressive symptoms” (p.236). However, contrary to their proposition in the introduction to the paper, directional effects could not be identified. The research design did not allow for such analysis because the participants were not assessed in any way prior to the delivery or pregnancy. The authors initially hypothesized that everyday stressors and life events would impact self-esteem negatively which in return would impact depression. However, it may be that women with low self-esteem perceive daily hassles to be stressful, more than women with high self-esteem do. Moreover, although the mediating effect of self-esteem on depression was significant, the direct effect of daily stressors on depression was stronger. We can conclude, at best, that there was some support for the hypothesis that self-esteem mediated the relationship between daily stressors and PPD, but we cannot be sure about the direction of that mediation or about what preceded what.

There were some other serious limitations to this study. The sample of convenience was not representative of the general population but rather was a seriously disadvantaged one. For example, over 50% of the participants were single mothers, and close to 70% were unemployed and had very little income. Research on stress and coping in single mothers has shown that they are more stressed, more depressed and manifest more psychosomatic symptoms than do married or cohabiting mothers (Compass & Williams, 1990; D’Ercole, 1988). Hall et al. (1996) did not collect any data on the

participants' history of mental illness, and they did not have a control group of depressed women who were not new mothers. It may be that women who live under such stressful conditions are more depressed than other women in general, and not only following child birth. Thus, we cannot be sure that this study addressed the specific phenomenon of postpartum depression. Also, the diagnosis of depression was based solely on one self-report measure ((CES-D). The drawbacks of such diagnoses have been discussed previously.

In conclusion, Hall et al.'s (1996) study has shown a strong link between daily stressors and depression in women. Self-esteem mediated between daily stressors and depression but the direct impact of daily stressors on depression was stronger. It was also impossible to determine the direction of that mediation.

Infant Temperament as Predictor of PPD

Beck (1996c) conducted a meta-analysis of 17 studies (published between 1974-1993) which had examined the relationship between postpartum depression and infant temperament. The result of the meta-analysis yielded a moderate correlation between postpartum depression and infant temperament. When weighted by sample size and year of publication, an interesting trend was detected: the larger the sample size, the smaller the effect size, and, the more recently a study was published, the smaller was the effect size. The author suggests that "the smaller effect sizes may reflect a more accurate portrayal of the relationship between postpartum depression and infant temperament" (p. 229).

Summary of Predictors of PPD

The extensive research in the area of predictors of PPD has provided some valuable information. Studies exploring possible correlation between certain biological variables and PPD have yielded inconclusive results. As well, some of these studies have had methodological problems, which may affect their reliability (e.g., Harris et al., 1996). Prenatal depression and childcare stress were found to be highly correlated with postpartum depression (Beck, 1996a). Life stress, social support, prenatal anxiety, history of depression and marital discord have been found to be moderately correlated with PPD (Beck, 1996a). Hall et al. (1996) found a strong correlation between low self-esteem and postpartum depression. Finally, infant temperament was found to have a weak correlation with postpartum depression (Beck, 1996b).

Methodological Approaches in Studying PPD

Having reviewed much of the literature in the area of the causes of PPD, Brockington (1996) commented that it seems that the possible causal factors of PPD are many, and most are inter-correlated. He goes on to say that "so far no large study has appeared, which makes a complete survey of all the main factors, so that their relative importance can be compared" (p. 181). In other words, Brockington (1996) suggests that an appropriate solution to the problem of studying the complex area of PPD would be a large-scale study that employs highly sophisticated statistics. Another possibility is to approach the investigation of this phenomenon in a different way altogether, i.e., to use qualitative rather than quantitative research methods. Because postpartum depression is such a complex phenomenon, approaching it from a holistic qualitative point of view may add some important insight into this phenomenon. Instead of trying to isolate variables

that may not be separable from one another, qualitative methods such as phenomenological research look at the experience of people in their context and as a whole, and only later examine the elements that constitute the experience (Colaizzi, 1978). Such research would not necessarily serve as a substitute for quantitative research in this area but rather, compliment it with a different angle that may shed more light on the phenomenon.

Quantitative research methods have been criticized as inappropriate or at least insufficient for the study of women and women's experience (Oberman & Josselson, 1996; Millman & Kanter, 1978; Sherif, 1987; Stoppard, 1999). Millman and Kanter (1987) criticize quantitative methods and research situations as being a hindrance to the process of getting accurate information from and about women:

Certain methodologies (frequently quantitative) and research situations (such as having male social scientists studying worlds involving women) may systematically prevent the elicitation of certain kinds of information, yet this undiscovered information may be the most important for explaining the phenomenon being studied. (p.35)

Along the same line, Sherif (1987) criticizes quantitative research methods as being biased and detached from the context:

The researcher decides, of course, often in highly arbitrary ways dictated by custom in previous research, not by what the person does or is doing in daily life. What are to be included as the all-important independent variables? Which aspects of the individual's behavior are to be noticed and which ignored during the research experience? The researcher makes all of these decisions, often forgetting at times that he or she is a human being who is part of the research situation too. (p.47)

Feminist researchers have postulated that it was best to study the maternal experience using qualitative research methods due to the complexity of the phenomenon and in order to enable the women's voices to be heard (Oberman & Josselson, 1996;

Millman & Kanter, 1987; Sherif, 1987). This observation seems to hold true for the experience of PPD, which is highly complex and varied. In fact, it is true for any human experience, be it male's or female's. Only qualitative methods can explore the full richness and complexity of the human experience within its context (Lamiell, 1996).

The research of PPD is overwhelmingly dominated by quantitative designs. Yet, there have been a few studies in this area that have employed qualitative research designs. For example, Beck (1992) studied the lived experience of women with PPD using a phenomenological design. Her research question was: "What is the essential structure of the lived experience of postpartum depression?" (p.165). Beck (1992) interviewed 7 women who were attending a support group for PPD. She presented the following question to each one of them: "Please describe a situation in which you experienced postpartum depression. Share all the thoughts, perceptions, and feelings you can recall until you have no more to say about the situation" (p. 167). Eleven theme clusters emerged from the data: 1. Unbearable loneliness, 2. Contemplation of death, 3. Obsessive thoughts, 4. Grief over loss of self, 5. Feelings of emptiness and boredom, 6. Fear and guilt of harming the child, 7. Inability to concentrate, 8. Lack of positive feelings, 9 Feelings of insanity brought about by anxiety attacks, 10. Loss of control of emotions, and, 11. Need for being mothered. The author notes that when comparing the themes that emerged from her study with the content areas that are covered by standardized measures used with PPD, these measures seem lacking. For example, the Edinburgh Postnatal Depression Scale (EPDS, Cox et al., 1987), which has been widely used with PPD women, covers only three of the eleven cluster themes of postpartum depression that emerged in this study. Similarly, the Beck Depression Inventory (BDI,

Beck et al., 1961) covers only 3 of the 11 themes that emerged, and it does not cover anxiety, which was a prominent component of the experience of the women in Beck's (1992) study. Thus, we begin to see the contribution of qualitative research designs to the understanding of the phenomenon of PPD. If we go back to quantitatively designed studies such as the ones by Fontaine and Jones (1997), and by Hall et al. (1996) which were reviewed previously in this dissertation, they were using the EPDS as a sole measurement of PPD. Thus, it may be that some participants in these studies were not identified as experiencing PPD because the EPDS failed to cover such a big number of themes that are prevalent for women who experience PPD.

An attempt at identifying the structure of the experience of PPD was later made by the same author (Beck, 1993) through the use of grounded theory. In Beck's (1993) study, twelve participants (seven of whom participated in the earlier study described above) were interviewed about their experience of PPD starting with the onset of symptoms and continuing through the recovery period. The findings were that loss of control was the basic social psychological problem for the participants. They attempted to cope with the loss of control through a four-stage process. The stages were:

1. Encountering terror, 2. Dying of self, 3. Struggling to survive and, 4. Regaining control.

Each stage had three components, e.g., stage 1- Encountering Terror's components were: anxiety attacks, fogginess, and obsessive thinking. Beck (1993) also provides a comparison of the results from her phenomenological study and the grounded theory study as a way of theory triangulation. According to Wilson and Hutchinson (1991) triangulation of two qualitative research methods illuminates realities that remain unknown if explored by other methods.

Beck's (1992, 1993) studies constitute an important step toward a better understanding of the phenomenon of postpartum depression. These studies allowed for the richness and complexity of the experience of the studied mothers to emerge. The quotes that the author provides allow the women's voices to be heard, which is rare in psychological research (Gilligan, 1982; Millman & Kanter, 1987). As well, Beck (1993) started the development process of a theory of postpartum depression. However, because as a rule qualitative studies cannot be generalized and because Beck (1993) was the first to attempt inductive theory development of PPD, much more research is needed in this area in order to further the understanding of this phenomenon and to arrive at a comprehensive theory of PPD.

Quantitative studies have indicated that PPD is associated to varying degrees with a multitude of variables that are not necessarily related solely to the woman, such as the quality of the marital relationship, social support, baby temperament and more. As well, previous research has ignored the context in which women with PPD function such as the family dynamics before, during and after the onset of PPD.

This study was designed to focus on the experience of women with PPD within its context. It employed the Grounded Theory Method (Glaser & Strauss, 1967), which has allowed for the participants' experience to emerge. Also, it enhanced the development of a substantive theory of PPD in its context.

Conclusion

The birth of a child is usually considered a happy occasion, and the weeks and months that follow are expected to be joyful and pleasing to the parents, especially to the mother (Badinter, 1981; Braverman, 1989; Crouch & Manderson, 1993; Thurer, 1994).

However, 10%-16% of recently delivered women experience prolonged and debilitating depression which is referred to as Postpartum Depression. The symptoms include tearfulness, despondency, feelings of inadequacy, guilt, anxiety, irritability, fatigue and poor functioning in general (Brockington & Kumar, 1982; Cox, 1986; Harris, 1994; Kendall-Tackett, 1993).

During the past few decades research in the area of postpartum depression has mostly focused on etiology, trying to determine the cause of this illness. Predictive variables such as cortisol levels in the mother's blood, prenatal anxiety, social support, previous psychological problems of the mother, baby temperament and many more, were studied in relation to postpartum depression (Beck, 1996a; Handley et al., 1980; Harris, 1994; O'Hara et al., 1984). These studies were unsuccessful in finding a specific cause for PPD. Correlations were found between PPD and a variety of variables such as baby temperament, marital satisfaction, prenatal anxiety and hormone levels, but the relative contribution of each of these variables has not been determined (Brockington, 1996).

The common denominator of the overwhelming majority of studies in the area of PPD is that they used quantitative designs, which aim at isolating variables and studying them in relation to PPD. These designs use deductive processes of theory development. As such, they start with preconceived ideas and hypotheses and observe the relationship between variables they hypothesize have a relationship. They test their hypotheses and study them while disregarding the context within which they operate.

Qualitative research methods are based on a holistic philosophy and explore issues within their contexts (Denzin & Lincoln, 1994; Guba & Lincoln, 1989; Lamiel, 1996). Of the various qualitative research methods, the Grounded Theory Method (Glaser

& Strauss, 1967) has been identified not only as highly rigorous but also as a method that promotes the inductive development of theory that is grounded in the data (Charmaz, 1996; Rafuls & Moon, 1996). The goals of this study were to explore the experience of postpartum depression from the point of view of the women who had it as well as to develop a substantive theory of PPD. The Grounded Theory Method (Glaser & Strauss, 1967) was chosen as the most appropriate research method that would enable me to achieve these goals.

At this point I will restate the research questions that guided the investigation in this study:

1. What is the lived experience of women who have had postpartum depression and have come out of it?
2. What are the psychological and social factors that play a role in a woman's experience of postpartum depression?
3. What is the structure of the experience of postpartum depression?

The next chapter outlines the methodological approach that has been used in this study with greater detail. As well, it describes the study procedures and explains the process of theory development.

CHAPTER III

METHODOLOGY

Rationale for Study Approach

The purpose of the Grounded Theory Method is to generate substantive theory that is grounded in the data, which will enhance our understanding of social and psychological phenomena (Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). Grounded theory is a naturalistic-inductive method, which means that, unlike quantitative methods one does not start with a theory that they are trying to verify. Rather, the grounded theory researcher begins the investigation with a broad area of interest, which they explore by asking very broad questions. The researcher then goes on to collect and analyze the data with the purpose of identifying abstract concepts and later hypothesizing plausible relationships between the identified concepts.

This study was designed to develop a theory regarding the social-psychological phenomenon of *Postpartum Depression*, which is grounded in empirical data. As was mentioned in the previous chapter, the phenomenon of postpartum depression has been extensively researched for the past three decades (Beck, 1996a; Brockington & Kumar, 1982; Cox, 1986). Nevertheless, previous research is lacking in three areas. First, the overwhelming majority of studies have employed quantitative research methods, which are not aimed at accessing the insider experience and view of the phenomenon, and thus, missing out on invaluable information (Denzin & Lincoln, 1994; Glaser & Strauss, 1967; Lamiell, 1996). Second, the phenomenon of postpartum depression was examined apart from its context. Specifically, many studies mostly examined women who had postpartum depression while ignoring other elements in the contexts these women

belonged to, such as their partners, extended families and communities. This is hardly surprising in light of quantitative designs' focus on examining relationships between variables stripped of their context (Denzin & Lincoln, 1994). As Lamiell (1996) puts it, the focus of quantitative research in the social sciences "had shifted from an interest in knowledge about *persons* to a concern for knowledge about *variables* (p. 144).

Finally, previous quantitative studies have failed at producing a comprehensive theory of postpartum depression. Rather, each study was designed to verify different parts of one theory or another. Moreover, as Brockington (1998) points out, there was no attempt on the part of researchers in the field, to study the relevant contribution of each of the many variables found to be related to postpartum depression.

A few qualitative studies have marked the beginning of an exploratory process whereby PPD is investigated in a holistic, inductive way that allows the women's experiences to emerge (Beck, 1992, 1993; Mauthner, 1999; Nicolson, 1999). As well, Beck (1993) started to develop a theory of PPD. This study was an attempt to continue this line of work and to further bridge the gap of knowledge in this area. It was designed to further the development of a theory of PPD, which is grounded in empirical data, to provide an emic (insider) view of the PPD and to take into account the context within which the phenomenon occurs. At this point it seems appropriate to outline my own ontological and epistemological assumptions because of their influence on my work and approach to research.

Methodological Assumptions

Ontological assumptions refer to the question: "what is the nature of reality?" (Creswell, 1998). My answer to this question is en par with the constructivist beliefs

about truth and reality, that is, that reality and truth are both subjective and are the result of perspective (Bruner, 1996; Schwandt, 1994). As Bruner (1996) puts it: "contrary to common-sense, there is no unique 'real world' that preexists and is independent of human mental activity and...symbolic language" (p. 95). Thus, my purpose as a researcher was to understand the lived experience from the perspective of the people who lived it, and to explore and understand the meanings that these people assign to their experience.

Epistemological assumptions refer to the question: "what is the relationship between the researcher and the person being researched?" (Creswell, 1998). Traditional positivistic approaches hold a dualist perspective, which views the researcher and participant as totally separate (Guba & Lincoln, 1989; Lamiell, 1986). The researcher is expected to conduct an objective inquiry and therefore should detach him/herself from the participant. I, however, hold the monist view, which maintains that pure objectivism is impossible and that the researcher's bias is bound to affect the participant. Therefore, the researcher and participant are interrelated and influence one another (Guba & Lincoln, 1989). As Guba and Lincoln (1989) point out, the inquirer and inquired-into become a single interactive entity which produces data. Furthermore, I believe that the participants are the primary 'knowers' (Denzin & Lincoln, 1994), and that therefore the women who experience postpartum depression are the experts. Thus, my interpretation comprises my own construction of the constructions of the participants (Schwandt, 1994).

The Case for Qualitative Research Design

In the *Handbook of qualitative research* Denzin and Lincoln (1994) write:

Human behavior... cannot be understood without reference to the meanings and purposes attached by human actors to their activities. Qualitative data... can provide rich insight into human behavior [by] uncovering emic (insider) views. (p. 106)

It was only in recent years that qualitative research designs were introduced to the field of psychology. Traditionally, psychological research was conducted from a positivistic approach and thus has exclusively employed quantitative research methods (Lamiell, 1996; Smith et al., 1996). In recent years, however, there has been a growing discontent with the “narrowness in the discipline of psychology, with its emphasis on laboratory studies, experimental design and statistical analysis” (Smith et al., 1996, p. 1). The result of this discontent was the introduction of qualitative research methods into the field of psychology. Albeit a very slow and gradual change, qualitative research methods have become more acceptable and have been used in psychological research in growing numbers (Smith et al., 1996; Sprenkle & Moon, 1996).

Qualitative research methods are being employed whenever existing knowledge is scarce or when the researcher suspects that existing knowledge may be biased. They are also used when the purpose of the study is to examine a phenomenon from the point of view of the people who experience it and are a part of it (Creswell, 1998; Smith et al., 1996).

In choosing among the various research methods available Grams (1998) suggests that it would be appropriate to choose an exploratory research method “if there is nothing known about the problem in question or, if the majority of what is known was deductively derived” (p. 5). Creswell (1998) adds that in choosing a specific qualitative research method over another qualitative method researchers should ask themselves ‘what is the purpose of my study?’ if the answer is ‘generating theory that would explain the phenomenon in its context’, then it is most appropriate to choose Grounded Theory.

In the next paragraph I will discuss the appropriateness of Grounded Theory as the research method for this study.

Previous studies in the area of Postpartum Depression have been lacking in more than one way. Specifically, most previous studies have neglected to examine the phenomenon of Postpartum Depression from the point of view of the women involved. As well, the context within which Postpartum Depression occurs was ignored. Employing a qualitative, and more specifically, a grounded theory design in this study has enabled me to explore the experiences of women who have PPD from their own perspectives, and to investigate the contextual processes that played a role in their experiences. Using the Grounded Theory Method has allowed me to reveal themes, which were not previously evident in the postpartum research literature as discussed in the findings and discussion chapters. Rigorous analysis of the data using a grounded theory method enhanced the development of a substantive theory of postpartum depression.

At this stage in the discussion it seems both helpful and necessary to briefly describe grounded theory methodology and discuss its importance for this study.

The Grounded Theory Method

The Grounded theory Method (Glaser & Strauss, 1967) has been defined as a general methodology for generating hypotheses and developing theory from qualitative data that has been systematically gathered and analyzed (Charmaz, 1996; Glaser & Strauss, 1967; Rafuls & Moon, 1996). Glaser and Strauss (1967) who first introduced grounded theory suggested that it would contribute toward “closing the embarrassing gap between theory and empirical research” (p. vii). They believed that this gap was formed by the overemphasis that had been placed on the verification of theory in sociological

research. Grounded theory was designed to provide researchers with a structured framework for generating substantive theory from empirical data. Substantive theory was defined as a theory that explains a specific area rather than a global and/or abstract concept (Glaser & Strauss, 1967). Researchers were to approach their study with an open-mindedness, not trying to prove any pre-conceived notions or theory, but rather, to explore and discover phenomena and relationships as they unfold through data collection and analysis (Charmaz, 1996; Lamiell, 1996; Rafuls & Moon, 1996; Strauss & Corbin, 1994).

In recent years, Glaser and Strauss developed divergent views of grounded theory methodology (Glaser, 1992; Strauss, 1987). Specifically, Glaser (1992) believes that in conducting grounded theory research, one should only deal with data that is relevant to the emerging theory and not with data that is forced into a preconceived analytical framework. Strauss (1987), on the other hand, believes that organizing the data is of utmost importance in the process of theory development, and that all data should be included and analyzed. As Strauss puts it, "the excellence of the research rests in large part on the excellence of the coding (P. 27).

Rafuls and Moon (1996) believe that the debate and controversy between Glaser (1978, 1992) and Strauss (1987) is healthy because it opens up more possibilities and introduces more variations to researchers. They suggest to avoid referring to a "correct way" or a "true way" to conduct grounded theory research because it "assumes ownership of a methodology that was created to get away from a one-sided perspective of research" (p. 67). According to Rafuls and Moon (1996) it would be best if each researcher decides for his/herself how to interpret and use the different procedures

offered by Glaser and Strauss, depending on their research questions and their expertise in conducting Ground Theory research.

In this study, I have chosen to follow Strauss' (1987) method of data analysis for two main reasons. First, as a novice researcher in Grounded Theory methodology who is committed to conducting rigorous work, I feel that Strauss provides specific guidelines and instructions that helped me conduct as rigorous study as possible. Second, I believe that following Strauss' (1987) data analysis procedures kept me open to any theme that may have come up in the course of the study, without limiting myself to preconceived ideas. Thus, by following the guidelines of an all inclusive data analysis I was more open to new themes and perspectives that have emerged from it. Being open and getting as broad a perspective of the phenomenon of PPD was one of the most important goals of my research.

Data Sources

Glaser and Strauss (1967) introduced the term of *Theoretical Sampling*. As they put it, theoretical sampling "is the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges" (p.45). Rafuls and Moon (1996) point out that theoretically based sampling usually emerges from the data after an initial part of it has been collected. They argue that theoretical sampling is not appropriate in the first stage of the study because the researcher should remain as open as possible to emerging themes. Therefore, they suggest a process of selective sampling which would be based on "a preconceived set of criteria that originates from the researcher's guiding assumptions and research questions" (p. 68).

That is, the researcher, having his/her research questions in mind, should define the selection criteria that would most probably yield the information that they are out to discover. At a later stage, when themes have emerged from the data, further theoretical sampling may ensue.

Data Collection and Analysis

Contrary to processes of data collection and analysis being separate from one another in quantitative research methods as well as some qualitative ones, these processes are interwoven in the Grounded Theory method. As Creswell (1998) puts it, the phase of data collection and analysis in grounded theory is that of “a zigzag process – out to the field to gather information, analyze the data, back to the field to gather more information, analyze the data, and so forth” (p. 57). Similarly Rafuls and Moon (1996) explain that the processes of data collection and data analysis are simultaneous, and data analysis “begins as one begins to collect data” (p. 70). This, they say, is the natural process stemming from the method of constant comparative analysis, for which Grounded Theory is known. This process involves a constant process of categorization, sorting, coding and re-coding of the data. Data collection ends when saturation has been achieved². For the sake of clarity of description, however, I will explain the process of data collection and data analysis separately, starting with data collection.

Sampling Procedures

Strauss and Corbin (1998) contend that data collection should be done in a way that will maximize the opportunities to discover as many variations as possible among

² Saturation has been defined as a state where new data does not provide new information (Creswell, 1998; Denzin & Lincoln, 1994; Lincoln & Guba, 1985).

concepts and to solidify categories. In the next section I describe the process of data collection in the initial stage of the study.

Initial Sampling

Strauss (1987) pointed out that initial or selective sampling should be based on locating individuals who are the most informed about the phenomenon under investigation in order to get the clearest possible picture of it. As Strauss (1987) puts it

Selective sampling refers to the calculated decision to sample a specific locale or type of interviewee according to a preconceived but reasonable initial set of dimensions... which are worked out in advance for a study (p. 39)

Therefore, as the phenomenon of interest in this study was women's experiences of postpartum depression, initial sampling included women who identified themselves as having had depression following childbirth, and who were willing to volunteer for this study. The volunteers' self-definition relating to having had depression following childbirth was accepted. There was no requirement for the participants to have been diagnosed by a health-care professional as having had postpartum depression. This was done in order to allow women who have not been formally diagnosed with postpartum depression or that were reluctant to use the term, to participate. Because the phenomenon of interest was women's experiences of depression following childbirth, their own definition was accepted as valid in this study.

The initial selection criteria of participants included the following: (a) women who identified themselves as having had depression following childbirth; (b) who indicated that they had come out of the depression at least a year earlier but not over 5 years earlier; (c) who were in an ongoing relationship with a male partner at the time of

the depression and were still with the same partner at the time of participation; (d) who were able to understand and speak English in order to be able to describe their experience of depression following childbirth; and (e) whose personal demographic background provided variation in areas such as culture, occupation and age. Following an initial sampling procedure came a somewhat different procedure called “theoretical sampling”.

Theoretical Sampling

A well-documented feature of grounded theory is *theoretical sampling*, which refers to data selection that is based on evolving theory (Glaser & Strauss, 1967; Strauss & Corbin, 1998). In other words, once the researcher has analyzed some of the data and has identified some of its concepts, further data selection is done according to the developing theory. This is done in order to achieve rich descriptions and comprehensive concepts. Further sampling is determined by the need to further investigate emerging categories and explore the relationships among them (Glaser & Strauss, 1967; Strauss, 1987; Strauss & Corbin, 1998). As Strauss postulated:

Theoretical sampling is a means whereby the analyst decides on analytic grounds what data to collect next and where to find them. The basic question in theoretical sampling is: What groups or subgroups of populations, events [or] activities does one turn to next in data collection. And for what theoretical purpose? So this process of data collection is controlled by the emerging theory (pp. 38-39)

In this study theoretical sampling was done in three ways: first, by changing the interview guide, second, by going back to previously transcribed interviews in order to look for categories or properties that may have been overlooked, and third, by screening new data for previously identified concepts. To clarify, I will provide examples of the three different ways in which theoretical sampling was used.

Theoretical sampling by adding questions to the interview guide occurred following an initial analysis of the first three interviews. For example, the first three participants started the interview by telling me about the time when they began feeling depressed. However, later in the interview they all referred to the time that elapsed between the birth and the onset of depression. I was curious to know what characterized the participants' experiences during that time and I added the following question to the interview guide: "please describe your experience following the birth and before you started to feel depressed". I asked this question in subsequent interviews. In this case theoretical sampling generated rich data that enhanced the solidification of the first phase of the women's experience, which I later labeled "Becoming Lost".

Theoretical sampling by going back to previously analyzed data occurred when a new category emerged from new data. For example, in interviews four, five and six the women described their experience of reaching out for professional help and being dismissed and misdiagnosed. Because these participants described this part of their experience in a vivid and powerful way, I decided to go back to the first three interviews and look for similar circumstances that I may have overlooked. Indeed, in two of the interviews I found references to similar experiences. While these references were less elaborate and powerful than the ones in the latter interviews, they still illustrated similar experiences. This led me to formulate the property entitled "reaching out for help".

Finally, after analyzing the data from the first twelve interviews I screened the last four interviews for data that further supported my emerging theory. Doing that, I reached the point of saturation, when new data did not provide new information. I was also able to include a larger variety of quotes to illustrate the different components of my theory.

Following the initial sampling and the theoretical sampling procedures I was able to solidify my substantive theory, making sure that categories and theoretical relationships between them and between their properties were described using multiple examples. Thus, the emerging substantive theory provides a plausible description and explanation of women's experience of postpartum depression.

Description of Study Sample

The participants in this study were 16 women who had experienced PPD and had come out of the depression. All of the participants were either married or in an ongoing relationship and cohabiting with a male partner during the time of the depression and at the time of participation. The participants were recruited in one of the following ways: 1. A letter of explanation about the study, asking for volunteers was sent to family physicians and psychiatrists in the Lower Mainland of B.C. The physicians were asked to bring the letter to the attention of suitable individuals, i.e., mothers who were in ongoing relationships with male partners. 2. A call for participants was posted in community centers around the Lower Mainland of B.C. and, 3. A call for participants was sent to members of the Pacific Postpartum Support Society, an organization that provides education in the area of PPD and offers support groups for mothers who have PPD (Appendix I). Volunteers were asked to phone the researcher and make an appointment for an interview. Thirty-four women volunteered to participate in the study but only 16 were interviewed due to the occurrence of saturation. The principle of saturation was discussed previously in this chapter. The women were selected on a first-come-first-serve basis. I.e., women were interviewed more or less in the order of phoning the researcher with minor variations according to participants' availability. During the phone

conversation that occurred when participants phoned to volunteer for the study I conducted a brief screening. I.e., I made sure that the women who phoned me met the inclusion criteria. I chose to exclude two women who said they were still depressed and were looking for help. I advised them to seek professional help as soon as possible. Table 3.1 presents the demographic characteristics of the sample.

Nine of the participants were drawn from the Lower Mainland of British Columbia, mostly in urban communities. The other seven participants lived in rural areas in BC outside of the Lower Mainland. Five of the participants responded to the letter sent to members of the postpartum support organization. The other 11 participants responded to posters in community centres and doctors' clinics. The participants ranged in age from 27 to 42 years old. As one of the inclusion criteria specified, they had all been in an ongoing relationship with a male partner, either married or cohabiting, both at the time of the depression and at the time of the interview. The participants all identified themselves as having experienced depression following childbirth. As well, they testified to having come out of the depression at least one year prior to participation and not longer than five years prior to participation. On the average, they perceived themselves to having been free of depression for 2.5 years. Four of the participants were first-time mothers, ten of them had two children and two had three children. Ten of the participants were Caucasian of whom seven were Canadian-born and three were born outside of Canada. Six participants belonged to visible minority groups and had immigrated to Canada between 6 and 27 years prior to the time of participation. None of the participants had immigrated to Canada during the last 5 years prior to participation. All except two of the participants

were working outside the home before the births of their children. At the time of the interview eight of the participants were back at their pre-birth jobs.

Four of the women quit their jobs and became "stay-home-mothers" and four changed jobs following the births of their children. The participants' level of education was above average as all of them completed high school and twelve of them had post-secondary degrees or diplomas. Most of the women described their financial situation as "fair", "good" or "very good". In general, the women in this study considered themselves to be "privileged" due to their financial situation, level of education and standard of living.

Confidentiality Issues

This study explored women's experiences of depression following childbirth. The women who participated shared personal and sometimes very intimate information. Therefore, it was of utmost importance to pay special attention to issues of confidentiality.

In order to assure confidentiality I took the following measures: 1. The interview tapes were kept in a secure and locked place in my home that only I had access to. 2. The transcriptions were stripped of any unique identifiers and were kept in a secure place, apart from the tapes. 3. Pseudonyms were assigned to all participants following a system known only to the researcher. These pseudonyms were used throughout this paper and will be used in any further written analysis and report. 4. Once the results of the study have been presented to the research committee, the interview tapes will be destroyed. 5. As is required by the ethics committee at the University of British Columbia, the transcripts will be retained for three years from the date of the successful defense of this

Table 3.1

Participants' Demographic Information

Name	Age	Education	Ethnic backgrd./ Pl. of birth	Years living in Canada	Occupatn. Before/ After birth	Marital status	Number of children
Helen	42	Post secondary	Caucasian/ Canada	N/A	Writer/ same	Married	1
Patsy	33	Post secondary	Caucasian/ Canada	N/A	Public health nurse/same	Married	3
Mary	27	Secondary	Caucasian/ Canada	N/A	Life-guard instructor/ same	Married	2
Jody	36	Post secondary	Caucasian/ Canada	N/A	High-school teacher/ same	Married	1
Lila	36	Post secondary	East-Indian/ India	29	Kindergart. Teacher/ Homemaker	Married	2
Sharon	42	Post secondary	Caucasian/ Canada	N/A	Graphic designer/ Counsellor	Married	2
Karen	38	Post secondary	E. Indian/ S. Africa	12	Government Clerk/ same	Married	2
Cynthia	38	Post secondary	Caucasian/ Canada	N/A	ESL teacher/ waitress	Married	2
Alicia	35	Post secondary	Caucasian/ Canada	N/A	Office adm-inistrator/ homemaker	Married	3
Dianne	30	Secondary	Caucasian/ U.S.	8	Office admin./ student	Married	2
Barb	27	Secondary	Oriental/ Hong Kong	12	Home maker/ same	Married	2
Nelly	31	Post secondary	Caucasian/ England	10	Lawyer/ Homemaker	Married	2
Ruth	40	Post secondary	E. Indian/ Canada	N/A	Computer analyst/ same	Co-habiting	1
Laura	35	Secondary	Oriental/ Japan	9	Office clerk/ same	Married	2
Kelly	27	Post secondary	Oriental/ Korea	6	Dental assist./ home maker	Married	1
Celeste	33	Post secondary	Caucasian/ S. Africa	12	Financial analyst/ same	Co-habiting	2

Interviewing Procedures

In this study, data were gathered via in-depth interviews with key informants. Each participant was interviewed twice. The initial interviews focused on participants' experience of depression following childbirth. During the follow up interviews participants were presented with a summary of the content and themes that emerged from the first interview and were asked to comment on it. All except one interview were conducted in participants' homes. One participant preferred to come to the researcher's home for the interview. The interviews were conducted between April 2000 and January 2001, and were audio-taped after participants signed the informed consent form (Appendix B). The first interviews were 1.5-2 hours long and were guided by an interview guide. The follow-up interviews were 45 to 60 minutes and were guided by a broad request made by the researcher for the participant to "please comment on this summary of our previous interview."

The Interview Guide

A semi-structured interview guide was designed to provide a flexible framework for the interviews (Appendix C). Using a semi-structured interview guide provided a unified framework for the data collection process while allowing me to be open to any new data that would come up and that I had not thought about before data collection. The questions in the interview guide were open-ended and broad, to facilitate the emerging experiences of the participants. As was discussed in the previous section, it was expected that the interview questions would evolve following the first few interviews (Strauss & Corbin, 1990, 1998). Indeed, the initial interview guide designed prior to commencement

of data collection (Appendix C) changed following the analysis of the first 3 interviews (see Appendix D).

The First Interview

My goal in each interview was to create a relaxed atmosphere that would be conducive to the participants opening up and sharing their experiences with me. I used the interpersonal and interviewing skills that I had acquired through my studies of counselling psychology. In particular, I used open-ended questions, reflection of participants' statements and empathy. I avoided judgment, opinion giving and advice giving. The interviews usually started with 5-10 minutes of "small talk". I then proceeded to ask the participant about her background. Specifically, I asked about her ethnic background, marital status, number of years in the relationship, number of children, level of education and occupation before the birth and at the time of the interview. I documented the information in the Participant Demographics and Background form (Appendix E).

Before I proceeded with my questions I reassured the women that they could say anything that was on their minds and they felt comfortable expressing, that there were no right or wrong answers and that nothing they say might spoil my research project because it was a project exploring their experiences. I chose to start in this way because I wanted the participants to feel free to describe their own experience as it happened without being concerned about whether or not they are saying the "right" thing. I thought about doing that because a few women who participated in a previous study I conducted had expressed a concern about whether or not they were being helpful to me and whether or

not I was getting what I had been looking for. I wanted to make sure that the participants in this study were not concerned about these issues.

I proceeded to ask the first question on the interview guide. From then on, I allowed the interview to flow naturally. I introduced further questions when a certain part of the experience seemed to have been described comprehensively, or to encourage further discussion of it. As described in the sampling section, the first few interviews were fairly broad while the later ones became gradually more focused and explored particular concepts that had emerged in previous interviews and that might be included in the evolving theory. My questions were carefully worded so as to minimize response bias that may stem from the participant's as well as my own knowledge of the literature on postpartum depression. Thus, the questions focused on the participant's experience rather than on common knowledge. For example, one of the questions was: "Can you tell me about your experience in terms of the relationship between you and your partner?" I avoided leading questions like: "Some participants have told me that their relationship with their partners have been affected by their depression". I also refrained from using terms like *postpartum depression*, *panic* and *anxiety* and only used them in reflection if/once the participants used them themselves.

It was my impression that most of the participants felt comfortable during the interview and described their experience in a very profound way. They sometimes became emotional when they remembered certain parts of their experience. At those times I used reflection rather than deflection. I stayed with the participants in the moment for as long as they needed. Many of the participants provided feedback to me at the end of the interview. They often said that it was a very interesting and pleasant experience

albeit sometimes difficult due to the emotions that surfaced as a result of going back to a painful experience. In concluding the interview I thanked the women for participating and made sure they had resources that they would be able to use in case they felt they needed some more processing or counselling for the issues that may have resurfaced due to the interview.

The Second Interview

During the second interview I presented the participants with a summary of the content of the initial interview as well as with themes that emerged from it. I asked the participants to comment on the summary and add or correct anything that they thought was unclear, incorrect or that they wanted to further elaborate on. The participants cooperated willingly and often expressed their satisfaction with the summary. A few added some information or clarified a statement. Their comments and clarifications were included in the data analysis.

Data Analysis

Strauss (1987) postulated that data analysis in a grounded theory study involved a process whereby a coding paradigm is used to identify concepts and the relationships among them. In this study I used three levels of data analysis: *open coding*, *axial coding*, and *selective coding*, in that order. As I progressed through the levels of data analysis the degree of analysis abstraction increased. Before the data could be analyzed the interviews had to be transcribed from the audiocassettes onto paper. I initially conducted 3 interviews in a row and then transcribed them verbatim. I then proceeded to conduct another three interviews and then transcribed these myself. I repeated this process one more time with another 3 interviews. Finally, I conducted another 7 interviews, the

transcription of which was done by a professional transcriber followed by data analysis by myself.

While working toward increasingly higher levels of abstraction, grounded theory is founded in the ideas that emerge from the earliest encounters with the data. Therefore it is recommended to engage in what Strauss and Corbin (1998) call “memo writing”. They define memos as “written records... that contain the products of analysis or directions for the analyst. They are meant to be analytical and conceptual rather than descriptive” (p. 217). I started writing memos immediately following the first interview. I tried to write shortly after each interview in order to remain as close as possible to my experience and my thoughts at the time of the interview. I also wrote memos whenever a thought, an idea or a question came up for me. I wrote *theoretical notes* and *operational notes*. My theoretical notes reflected my reaction to the interviews as well as my ideas and thoughts on potentially relevant categories, their properties, relationships and process (Strauss & Corbin, 1998). Following is an example of a theoretical note I wrote after one of my first interviews:

Theoretical Notes: An Example

What struck me the most in Sharon’s story was the way she was completely isolated. She was very very lonely because of the lack of support but also because she was ashamed of herself and wouldn’t reach out to people for fear of social criticism and rejection. Another thing was that her husband didn’t get it. He didn’t get how serious her situation was and just wanted her to be ok.

My operational notes consisted of my thoughts regarding sampling, coding, questions, technical matters and leads to be followed up (Strauss & Corbin, 1998). An example of an operational note that I wrote after analyzing the first three interviews:

The process of open coding is done by breaking down the data into small meaning units such as a sentence or a phrase and trying to identify the core idea that is presented in these units. The close examination of the data yielded code names, which reflected the essence of the participants' words. As Strauss and Corbin (1998) suggest, code names often used the participants' language in order to remain as close as possible to the raw data.

Axial Coding

After completing the open coding process for the first three interviews, I began to systematically group codes into code names and code names into properties and later, categories. This process has been named Axial Coding (Charmaz, 1996; Creswell, 1998; Grams, 1998; Rafuls & Moon, 1996; Strauss & Corbin, 1990, 1998). A category refers to a theme, a part of the process or a pattern of behavior that can be identified in the data. Categorization elevates the level of abstraction with which the data is being analyzed (Strauss & Corbin, 1990, 1998). The process of axial coding also led me to start developing the theoretical framework, which in turn, generated more questions and further data collection and analysis. In working on the theoretical framework, I examined categories in terms of their properties (characteristics). The code names from the open coding process often represented types, circumstances and conditions that were salient in each property of each category (Glaser & Strauss, 1967; Grams, 1998; Strauss & Corbin, 1998). The following is an example of the property of isolation as it emerged from a comparison of excerpts from the first three interviews:

The emerging of *Isolation* as a property

Karen: I was so lonely... it was such long, long hours alone with the baby... it just seemed endless... I had nobody... nobody to talk to... I was in the house just me and him...

Kelly: I didn't know anybody in this neighborhood... I was alone all the time... I needed someone to talk to but I was away from everyone...

Mary: I didn't know anybody around here 'cause we'd just moved so... it'd be days and days before I'd talk to someone... except for my husband but he was never home... my kids... didn't take away the isolation...

Throughout the process of data analysis I used a process of *constant comparison* (Glaser & Strauss, 1967; Strauss & Corbin, 1998). This process involves systematically comparing different units of data. Comparisons are made in the following ways: (a) comparing, or looking for similarities and differences in the data from one participant, for example similarities and differences of the properties of different phases in the experience, (b) comparing similarities and differences among participants, such as their views, behaviors, perceptions and experiences, (c) comparing new data with previously defined categories, and (d) comparing a category with other categories.

As categories were identified and defined, the theoretical framework continued to grow and become more comprehensive. The categories, their properties and the types, circumstances and conditions that made them up were constantly tested by going back to old interviews and by asking new participants for validation or refutation (Strauss & Corbin, 1998). This process was continued until the concepts and propositions were cohesive and a state of saturation has been reached (i.e., no new information would emerge).

At that stage I attempted to identify the relationships between categories and formed propositions relating to these relationships. I also engaged in a process whereby I made connections between categories and their subcategories (Strauss & Corbin, 1998). As the data analysis progressed, it became obvious that certain categories were richer than others and were inherent to the experience (e.g., “being trapped by depression”). Other categories were increasingly becoming more peripheral as they were lacking the richness and depth that other ones had and were not evident in other data (e.g., “sick baby”).

The grounded theory method of analyzing the data helped me to develop increasingly more abstract categories while remaining true to the data and grounded in it. In determining the limits of each category I reviewed all of the coded data that was related to it. In this manner both the unique characteristics of each category were identified as well as its boundaries. Using theoretical sampling and constant comparative analysis I continued the analysis until the major categories, their properties and the propositions regarding their relationships were defined.

Selective Coding

As the concepts that emerged from the analysis became more and more cohesive I employed a technique, which Strauss and Corbin (1998) name *selective coding*. In this technique categories are positioned in the theoretical framework so as to represent their place in relation to other categories. At this level the researcher is dealing with categories that seem core to the experience under investigation, and in the relationship among them. Thus, at this stage I had already identified the different phases of the experience of postpartum depression. My challenge was to find the relationships among the phases and

the sequence in which they appeared. For example, I identified a phase where the women were experiencing the impact of fully blown depression, which I entitled "Deep in Depression". Another phase that I had identified happened when the women were starting to break out of the depression. Using the process of selective coding I worked to identify the relationship between these two phases. I found that there was a cyclical process whereby women who tried to break out of the depression by seeking professional help were often dismissed and misdiagnosed. They then relapsed back to a hopeless and passive state where they were deep in depression yet again. An examination of the data validated the cyclical relationship between these two phases. Thus, Breaking Out and Deep in Depression were integrated as parts of the larger theoretical model of the experience of postpartum depression.

Criteria for Judging Rigor

Strauss and Corbin (1990, 1998) posited that theories that are generated by using the grounded theory method are judged by evaluating their theoretical soundness and their usefulness in both theoretical and practical terms. Methodological soundness refers to: (a) the trustworthiness of the data and findings, (b) the empirical grounding of the research findings, and (c) the extent to which the researcher followed a rigorous research process through which the theory was generated. The usefulness of a theory is defined by the extent to which it contributes to the knowledge in the area of interest as well as by the extent to which it can guide practice in relevant areas.

In conducting this study I made a concerted effort to meet the criteria for rigor. First, validation of the content of the interviews was obtained from the participants in the following manner: after transcribing each interview I wrote a summary of the main

events, actions, feelings and perceptions that constituted the woman's experience as she had described it to me. I then met with the participants, presented the summary and asked for their comments. While all of them validated the summaries, two wanted to add some more details. In these cases I took notes of their words and made sure I included them in my analysis. Second, I made a point of going back to the raw data as abstract concepts were forming, looking to anchor these concepts in the data. The transcriptions were in front of me throughout the whole process of data analysis so that they were available to me for reexamination. Thus, I could make sure that my findings were grounded in the data. Third, at the time I was conducting my data collection and analysis I participated in a grounded theory study group guided by Dr. Katharine May, a researcher at the University of British Columbia who has conducted many studies using grounded theory. Dr. May had trained with Barney Glaser, one of the founders of the Grounded Theory Method at the University of California in San Francisco. One of the things we did in the group was to analyze our own data, with the help of our colleagues. Specifically, the group analyzed six of my interviews in terms of code name. I.e., I provided the group with excerpt from 6 interviews that had common themes and asked them to assign a code name to each cluster of quotes. A group discussion followed, and the members of the group validated the overwhelming majority of the code names I had previously assigned to these segments. Two code names were slightly altered following the group discussion.

Also, I worked closely with my supervisor, Dr. Garry Grams, who is very knowledgeable and experienced in the Grounded Theory Method. Dr. Grams followed the process of data collection and analysis. Together we made sure that the process strictly adhered to the guidelines for conducting grounded theory research, as outlined in

relevant writings (Charmaz 1996, 2000; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). Finally, I stated my own bias and was aware of it throughout the process. I kept writing self-reflective memos questioning my own analysis. I documented my reaction to data that was different from my own experience and beliefs and made a point of further investigating it. For example, prior to data collection I believed that depressed mothers did not attempt suicide because they did not want to abandon their children. When I interviewed a few participants who had entertained the thought of committing suicide, I found out that at a certain stage most of them believed that their children would be better off without them. Therefore, another reason for why they did not attempt suicide needed to be explored. Thus, by maintaining awareness of my own biases, by seeking the validation of participants and peers and by adhering to the indicated process of data collection and analysis I made sure that my study was conducted in a highly rigorous way.

Summary

This study utilized the Grounded Theory Method, which was initially described by Glaser and Strauss (1967). The underlying assumptions of this method emerged from an interactionist philosophy as well as from the traditions of naturalistic field research. The data in this study were collected via semi-structured interviews with key informants, i.e., women who had experienced depression following childbirth. Sampling was done in two ways: first, there was initial sampling with key informants and then there was theoretical sampling where emerging constructs led to further investigation. Analysis of the data followed the process of constant comparison (Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). There were three levels to the analysis: open coding, axial coding

and selective coding. The development of a theory was done inductively through analyzing recurrent themes and concepts in the data. Deductions regarding the relationships among concepts were hypothesized, modified or rejected in light of new data, which was continuously added as more interviews were conducted. The result was a substantive theory on women's experiences of postpartum depression. The theoretical model that was developed from the data, was grounded in the data and fit the data.

CHAPTER IV

STUDY FINDINGS

The result of this study is a substantive theory developed to explain women's experiences of postpartum depression. This theory may be considered middle-range, in that it "falls between the 'minor working hypotheses' of everyday life and the 'all-inclusive' grand theories" (Glaser & Strauss, 1976, p. 33). The theoretical framework that emerged from the data collected for this study is represented in table 4.1. This table includes the six phases of the experience of postpartum depression. A graphic overview of the theoretical model that emerged from this study is represented in Figure 1. This figure illustrates the phases of the experience as well as the themes that emerged from the data: (a) the relationship with the partner, and (b) a redefined self.

The theoretical model conceptualises women's experience of postpartum depression. It perceives this experience as a social-psychological process. Thus, this study focuses on the participants' experience of postpartum depression in its context and as it was affected by both social and psychological factors.

Participants' thoughts, beliefs, behaviors and feelings that surfaced in the interviews interacted with one another to create a composite picture of redefining self through the experience of depression the way it happened for these participants. The model conceptualises this experience as a six-phase process whereby the participants became depressed following childbirth and eventually came out of depression and experienced a redefinition of their selves. The phases in this model, which will be explained and illustrated in table 4.1 are as follows: Becoming Lost, Getting Trapped, Deep in Depression, Struggling to Break Out, Breaking Out and Staying Well.

Table 4.1
Theoretical Framework of The Experience of Postpartum Depression

Categories/phases	Properties	Types, Circumstances & Conditions
Becoming lost	Denial of self	Denial of physical needs Denial of emotional needs Denial of personal freedom
	Isolation	Being alone Being lonely
Getting trapped	Becoming overpowered	Being suddenly hit by depression Facing the power of depression
	Becoming paralysed	Experiencing helplessness Failing to escape
Deep in depression	Being Overwhelmed	Becoming overwhelmed Functioning poorly Losing hope
	Going insane	Thoughts of harming the baby/children Anxiety and panic attacks
	Disowning self	Experiencing shame Self-blame Self-hatred Suicidal thoughts
Struggling to break out	Attempting self-help	Going out Meditating
	Reaching out for help	Looking for information Looking for professional help
Breaking out	Becoming aware of PPD	Self-diagnosing Getting diagnosed
	Getting treatment for PPD	Going on medication Getting counselling
Staying well	Self-care	Fulfilling physical needs Fulfilling emotional needs Redefining personal freedom
	Redefining relationships	Redefining the mother-child relationship Redefining relationships with others

A presentation and discussion of each of the six phases of the model appears in the next few sections of this paper.

Woven into the six phases of the experience of postpartum depression was the theme of the participants' relationships with their partners. This theme kept resurfacing in different parts of the data and was not related to one phase or another, i.e., the participants revisited the issue of their relationships with their partners in different times in the interviews while they were describing different phases of their experience. The relationship with the partner is mentioned in the discussion of each phase where it naturally appeared in the women's stories. As well, the last section of this chapter presents a more comprehensive overview of this theme. The issue of emotional closeness versus distance between the women and their partners is particularly elaborated on. Finally, the concept of a redefined self that emerged from the women's stories is discussed.

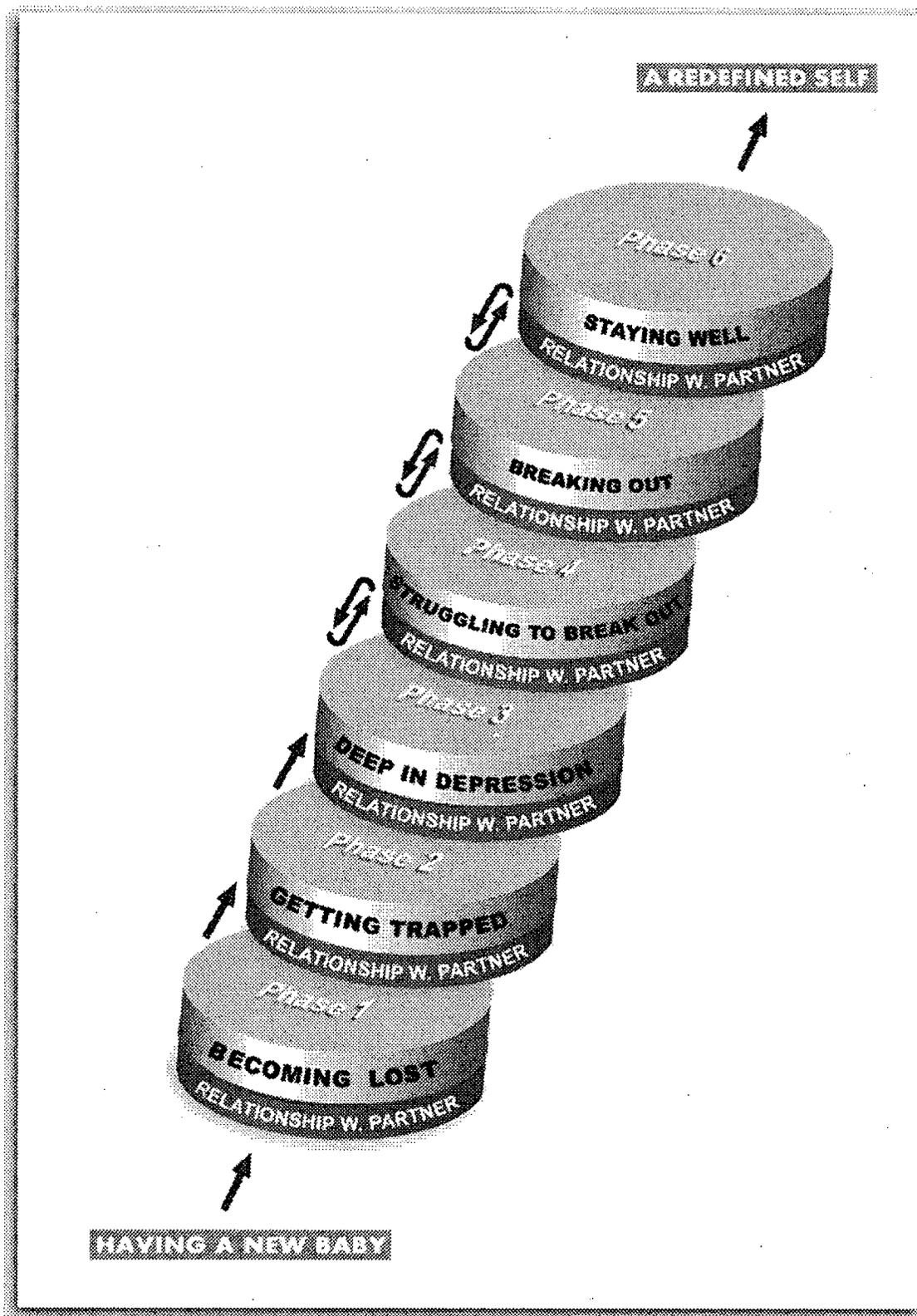


Figure 1. The theoretical model of "The Experience of Postpartum Depression"

Figure 1 illustrates the phases in the transition from having a baby to a redefined self. Although these phases appear to be linear, the transitions between phases number 3 and 4, 4 and 5 and 5 and 6 were cyclical, i.e., participants moved back and forth between these phases at a given period of time until they eventually moved forward. This idea is discussed in more detail in the following sections of this chapter.

Overall, the theoretical model represents participants' experiences not only of becoming depressed following childbirth but also their road to recovery. In other words, what were the things that either the women did or that happened in their environment that contributed to both their depression and their coming out of it and the ways it contributed to the redefinition of self. Relationships among different properties and conditions that were identified in this model are presented in the form of propositions in accordance with the procedures of grounded theory as outlined by Glaser and Strauss (1967) and as explained in more detail in the methodology chapter.

In the next few sections I am presenting the six phases of the model, the properties that make up each phase, and the types, circumstances and conditions under which those properties exist. I will use quotes from the women, altered to protect their anonymity, to both illustrate and ground the theory in the experiences of these participants. Each section will end with a summary and the theoretical propositions that emerged from the results.

Phase No. 1: Becoming Lost

Becoming lost has emerged as the first phase in the theoretical model of the experience of postpartum depression. Figure 2 illustrates the internal relationships among the different properties of this phase as well as the relationship between this phase and the rest of the model.

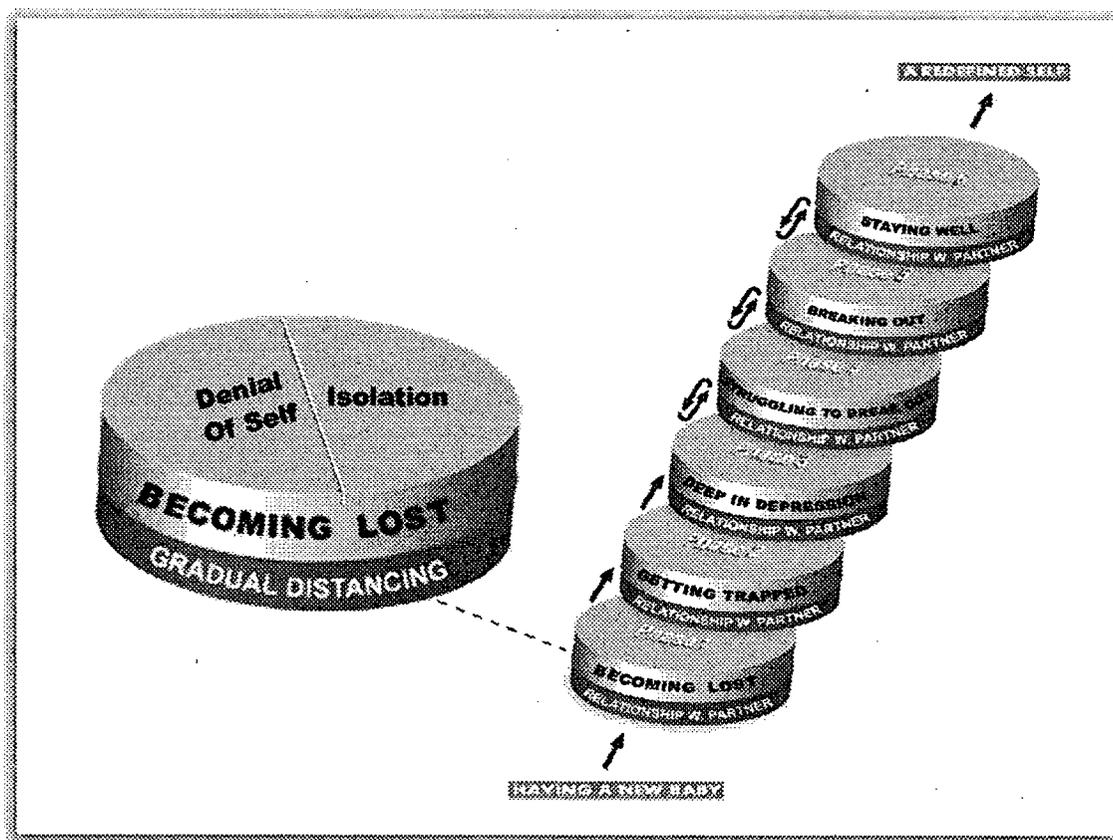


Figure 2. Becoming Lost. Phase no. 1 in the six-phase model of "The experience of postpartum depression".

Figure 2 illustrates the two properties that characterise this phase, Denial of Self and Isolation. Both properties coexist and have an equal contribution to this phase.

When asked about their experience of depression participants often started by describing the onset of depression, which occurred between the 2nd and 10th week postpartum. When asked to look back on the period following the birth and before the onset of depression participants described a process by which they had gradually become lost. The meaning of being or becoming lost for the participants was that they experienced a loss of sense of their selves, time and the outside world, all through isolation and aloneness. For example Karen recalled:

There was no difference between day and night. It all became one big blur. I wasn't getting any sleep... I was so fatigued, and it didn't matter anymore if it was day or night outside... and I just remember being in a thick cloud, all by myself, not knowing where I was, or who I was for that matter...

The process of becoming lost started very shortly after the birth, often in the first few days of being home with the baby. The process had two main properties: Denial of Self and Being Isolated.

Denial of Self

Upon arrival at home after the birth participants immediately resumed their pre-birth responsibilities like cooking, cleaning, doing the laundry and shopping as well as caring for their new babies. About half of the participants also had to take care of older children ranging in age from 1-4 years. In most cases the partner would take a day or two off work following the birth and then go back to work, resuming his pre-birth schedule. The women stayed at home and performed the overwhelming majority of child-care and household chores. During that time the women's own physical and emotional needs were being denied.

Denial of Physical Needs

Being constantly busy with the baby or children and household chores the women's physical needs were pushed aside and sometimes completely denied. Their basic needs like sleeping, eating and showering were seldom fulfilled as Karen described:

He wasn't a fussy baby but still I was busy all the time; if it wasn't feeding, changing a diaper or just holding him, it was cleaning the house and taking care of bills and other stuff like that. And doing everything while being exhausted... drained like you have nothing to give... and I would forget to eat and sometimes – I'm embarrassed to say – I'd forget to shower for days...

Kelly remembered a similar experience. She perceived her baby to be very needy and described how her constant caring for him affected her:

I was so tired all the time... I mean really exhausted. I was getting up six, seven, eight times a night and the baby wouldn't nap during the day except short... cat naps. I was in a thick cloud all the time, not seeing clearly... sometimes not even knowing what day it was. Just thinking about it... I was wiped... I could cry simply out of exhaustion. And this thing went on and on and on... it was unbelievable.

As is obvious from these recounts participants not only felt exhausted and drained, but also experienced being always on the go, never stopping for a break. Patsy described how having to continuously care for her baby who she defined as "needy" had caused her to lose her sense of time:

I found the baby to be a very needy... needy baby. Like he just... no one else would do it – it had to be Mom. And he just clung to me. He wouldn't take the bottle... I was nursing him so I just never ever got a break... it was just one day after the other and they all melted into each other.

Kelly had to take care of her newborn baby-boy and her 14 month old daughter. She described a never-ending stretch of days of not getting a break:

The baby was constantly on me and my daughter was also on me all the time. She was just a baby herself and she wanted me all the time. I was constantly on the go, from one thing to another... never-ending and never a break day after day after day... and everything was about them, the kids. I didn't exist as a person... I didn't matter...

These mothers described how desperate for a break they had become after weeks or months of being constantly busy with no break. They mostly needed a break from their children but rarely got one. Some of them needed a break so badly that they wished they would get physically ill and would have to be hospitalized as Sharon recalls:

I remember wishing that I was sick enough to be put in a hospital... not having depression but having something wrong with me physically... I could never leave the baby with anybody else, and it just drove me nuts! So I wished that I'd be put in a hospital so I'd have a break... so I can get away from him.

Thus, participants experienced a pronounced denial of their physical needs. Things that are normally taken for granted such as sleeping, eating, taking a shower and stopping for a break were almost completely denied of them. As a result of the denial of their physical needs women were left exhausted, drained and foggy. They were so desperately in need of sleep, rest and a break that they sometimes wished they would become physically sick so that they could be taken care of and have a 'legitimate' break.

Denial of Emotional Needs

While participants endured ongoing deprivation of their physical needs, another aspect of their existence, a less obvious one, was being deprived as well: their emotional being. Participants defined an emotional need as "something you need for your soul... some support that you get as opposed to always be giving" (Mary) or "something that makes you feel good about yourself, special... like you're being taken care of, appreciated." (Helen). The women mostly described a need to be supported, appreciated and nurtured. They expected their partners to provide them with support and emotional nurturance and were gravely disappointed when that rarely happened as Kelly described:

My partner was very insensitive... you know... he doesn't think of these things and I just wanted... all I wanted from him was cuddling... and nurturing... I wanted this

wrap around... I wanted to get what I was giving to the kids... I felt like everything was taken away from me physically and emotionally...

Sharon recalled how she desperately needed her partner to “be there” for her and how she became angry and resentful when he was not:

Peter and I were a very strong couple... and what happened was that I needed him so much to be there for me, I needed him to understand and to love me and appreciate me and it just didn't happen... and I was so angry at him for not being there for me... I resented him for not being there for me...

Similarly, Karen described how devastated she was when she realized her partner was not able to give her the emotional support she needed and expected him to provide her with after the birth:

What happened was, I think, that verbally my partner took responsibility but emotionally he didn't actually take responsibility and I felt I'd been let down by him and that was a big shock to me 'cause up until then in my life I'd always felt very supported by him and never felt that he'd let me down... and I just looked at him and thought 'you're not the person I thought you were because... you're not able to help me-you just don't seem to know what to say or do to comfort me'.

Cynthia was very explicit in requesting her partner's emotional support, but was extremely disappointed when her partner dismissed her plea:

I just felt very alone. Very alone in this world of motherhood... and finally I just broke down crying and said 'all I want is for you to wrap your arms around me and just hug me and tell me it's ok, or run your fingers through my hair and say you understand...' but my partner just pooh poohed the woman thing: 'Oh, you're just being emotional or over-reactive or you're expecting too much...'

The women, then, missed being supported and nurtured during the first few weeks after the birth. They expected to get support and nurture mostly from their partners and were extremely disappointed when they perceived their partners either could not or would not provide them with what they needed.

Another need that participants mentioned was that of personal space. Participants described a desire to not only have time for themselves but also an ability to think, feel and be women rather than constantly being in the role of mothers. Thus, the need for a break and personal space had both physical and emotional components. Cynthia remembered how this need had been denied from her during the first few weeks following the birth of her daughter:

The baby was nursing every 2 hours or so... she was a hungry baby (laughs). So I was with her all the time, never having a moment to myself and never able to stop for a minute and look at my self... as a person, a woman, a human being with needs, wants and wishes. I was merely surviving... or trying to... I basically didn't have a minute to myself... I couldn't breathe.

Lila remembered her excitement when she had to go and see her obstetrician six weeks following the birth. Not having a break in the weeks following the birth, she relished the opportunity to be on her own for a short time:

It was actually my Mom who asked me about it... I mean it hadn't even occurred to me to go and get checked... I completely forgot about it, you know, the 6 weeks (postpartum) check up. I thought to myself 'what a delightful idea!... just the thought of doing something that meant taking care of myself, and being on my own for an hour or so, going there and sitting in the wait room reading magazines... it was great! But then I came back home to the same old same old.

Participants perceived having been denied their emotional needs as well as their physical needs during the weeks following the birth. Specifically, they missed being nurtured and supported, being appreciated, getting a break and having some personal space. Having no personal space was related to a larger aspect of human existence that they perceived had been denied from them: their personal freedom.

Denial of personal freedom

Participants described how following the birth they felt that their freedom had been taken away from them. To the participants in this study, freedom meant being able

to go places and engage in activities in and outside of home as they pleased. Soon after the birth they realized that the babies, not they themselves, were in charge of their lives.

Laura remembered how this denial of freedom had surprised her:

Suddenly everything is for the baby, about the baby, around the baby. You don't exist anymore. If you want to do something, well...forget it! You can't go out now because he's napping and later he's gonna have to nurse and then it's raining and you don't want him to catch a cold... I was simply shocked at how my life... my choices... my freedom were taken away from me all at once.

Laura and some other participants who were first-time mothers were surprised by the loss of their freedom. Unlike them, women who had had children before were not completely surprised by it but still, they did not expect another child to put as many constraints on their freedom as they actually experienced, as Celeste explained:

[When I only had one child] I wasn't as free to do my own thing as before I had her, of course, but I would still go out and do things much more often. I would simply take her with me or we would even take her with us to the movies... but with two kids - forget it! It became just too complicated and such a big chore; to just pack everything and remember everything... I simply gave up on getting out of the house.

Nelly, who became depressed following the birth of her second child, had a similar experience to that of Celeste:

I remember thinking when I was pregnant with my second child that it won't be that hard because I've already given up my freedom when I had my first. But was I ever wrong (laughs)... it was way worse than I expected... taking care of the two of them, I simply had no time to do anything that I wanted to do. I just was going from one thing to the other and never had the time to do the things I actually enjoyed doing for myself.

For Kelly, a dental hygienist, denial of her personal freedom took a different form than that of the others. Kelly wanted to go back to work part-time when her baby was 2 months old. Her partner and other members of her family were against it and put a lot of pressure on her not to do so:

I loved my work, and I missed it. I was bored out of my skull with the baby and I felt I wasn't accomplishing anything. I felt like I didn't know what I was doing... my partner thought I was out of my mind and my Mom and my sister were saying 'what did you have a child for? So that others will take care of him? They made me feel guilty and I gave up... I felt like somebody put a chain around my neck... I became a prisoner.

At the same time as participants experienced denial of many aspects of their selves, they also endured remarkable isolation.

Isolation

The women in this study remembered the period following the birth as a time when they were constantly by themselves, isolated from the outside world and away from family and friends. Being the primary care givers of their babies/children and performing the overwhelming majority of household chores resulted in separation and isolation from the outside world. Also, spending time with their babies/children did not allow for much contact with other adults, which the women missed greatly. Being isolated manifested itself both through physically being on one's own and feeling lonely and abandoned as Ruth described:

I was mostly home with the baby and I didn't get much opportunity to communicate with other people. I felt very isolated. That winter was an awful, awful winter. It was pouring rain all the time and I just stayed home with her and felt very lonely. I mean I loved her and everything but still those days felt very lonesome... I felt lost... deserted... no one was there for me...

As Ruth's words indicate isolation consisted of technically being alone as well as feeling lonely, which was the emotional side of the experience.

Being Alone

The women who participated in this study were alone with their babies/children during most of time, day and night. They were at home alone when their partners were at work during the day and at night, most of them had to get up when their babies were

crying. Most partners did not share night-time responsibilities because they “had to have a good night sleep to be able to go to work in the morning” (Lila). Most of the participants’ relatives had been living in other communities, provinces or countries. They did not visit very often and thus were not available. Friends were seldom a source of help because they were either busy with their own lives or did not have children of their own which contributed to different interests and some distance in the relationships. Sharon described a typical situation of being home alone while the partner is at work, and away from any other family:

I was constantly home alone with the kids. My partner was working all the time... he worked two jobs and was just not available. And we had no family here so no support at all... I had nobody.

Patsy remembered how unavailable her partner had been and how alone she had been during the months following the birth of her second child:

I just found that I was constantly alone at home just 'cause my partner was always working on one thing or another... he would just breeze in at 10:30, 11:00 at night. I'd be in bed already and he'd be gone before I got up and it was just one day after the next... I just felt that he was never there because he was just so busy all the time.

Kelly, whose partner and relatives were unavailable to her, had two very good friends who, she had believed, would be helpful, supportive and would keep her company once the baby arrived. To her surprise and dismay, these friends did not seem to be interested in providing any instrumental help to Kelly or keep her company when her baby was born. Rather they expected to socialise with Kelly the way they had done before the birth, as if nothing had changed:

I thought they would be interested... I didn't think they'd have no interest... no interest whatsoever in holding him or playing with him or even just being with me when I'm taking care of him... they just wanted to go out together and I was so

tired I just wanted someone to take him for a little while... and by the evening I was just so wiped and they'd be like 'let's go and see such and such in the movies' and I'd just tell them to go ahead and next time I'll come 'cause I was just totally pooped'.

Kelly's loneliest times were during the days when her partner was at work and her friends were busy with work and school. Because her life was different from the lives of her friends, their schedule did not match her own anymore. Moreover, their focus and interests became too different. Thus she was left with little adult company.

As the women alluded to, there is a difference between being alone and being lonely. Being alone refers to a physical distance from other people and does not bear either a negative or a positive value. Being lonely refers to a negative feeling of missing the company of others and having a sense of being emotionally alone in the world with no one who is emotionally close to you. One can be alone and isolated from other human beings and not feel lonely. On the other hand, one can be surrounded by people and still feel lonely. The women in this study experienced both aloneness and loneliness.

Being Lonely

As described above the participants in this study were mostly alone with their babies/children. In addition, they experienced a sense of loneliness, as if they had been deserted and forgotten. Karen described how she used to beg her partner to stay with her and not go to work because she felt very lonely when he was gone:

I dreaded the mornings when my partner would leave me alone with the baby and go to work. I was so lonely... I used to say to my husband: 'don't go to work! Can't you call in? Can't you rearrange the events for tomorrow or whatever? Just take today off' and 'I can't cope and I won't be able to and I can't be alone'. Because you see, it was such long, long hours... alone with the baby and every morning it seemed endless... and I would get very, very lonely.

Barb and her partner who had moved to a new home while Barb was pregnant did not know anybody in their new neighborhood. Both Barb's and her partner's families lived in Eastern Canada. Like all other participants Barb was home with her children while her partner was working long hours. This is how she described her loneliness and yearning for connection with other people:

I was so miserable. My son was a very fussy baby. He was crying all day and wouldn't nap. I was just so tired but couldn't sleep, and alone all the time. My partner used to work all the time and wasn't even aware... I just needed someone to talk to. I didn't know anybody in this neighborhood. I didn't find being with the kids to fulfill my need for company. I was feeling very lonely... I just needed a friend.

Much like Barb, Mary and her partner had moved to a new neighborhood just before the birth of their second son. Mary, who used to work as a lifeguard instructor before the birth, found herself home alone with her two very young children in a very secluded area.

She described the way her loneliness accompanied her aloneness:

We'd just moved here and it's... as you can see it's pretty isolated and I didn't know anybody around here so it'd be days and days before I'd talk to someone... except for my partner... but he was never home. He was at work all the time and when he didn't work he volunteered at the fire station. So, I mean, I love my kids and all that, but being with them didn't take away the isolation... just being lonely all the time... very, very lonely.

As was evident in the women's testimonies, they experienced being both alone and lonely most of the time, having no one to share their responsibilities and work load with, no one to talk to, to consult with or get advice, support or help from. This physical and emotional isolation went on for many weeks and even months and was present not only in this phase, but as described later, in other phases as well.

The Relationship with the Partner: Gradual Distancing

During the first few weeks following the birth participants were mostly home with their baby/children while their partners were at work, usually for long hours. Thus, shortly after the birth couples assumed the traditional roles of the male being the provider and the female being the care-taker and nurturer of the family. During these long days and weeks the worlds of the partners became more and more different; while the male partners were engaged in work-related activities and other activities outside of the home the women were mostly at home and rarely engaged in activities other than child-care and house chores. As well, while the men's life-style changed only slightly since the birth, the women's life-style changed profoundly, especially if they were first-time mothers. The participants, who suffered the denial of both their physical and emotional needs, became angry and resentful toward their partners. As mentioned earlier, they expected their partners to share some responsibilities with them and to be emotionally supportive and available to them. When their partners did not show the kind of support that they expected from them and when they felt disconnected from the rest of the world participants felt isolated, lonely and neglected. At the same time they began to emotionally drift apart from their partners. The process of distancing in the couple relationship has begun, as Helen described:

It seemed so strange... he was in his own world and I was stuck at home... I thought he wasn't interested... we were kinda drifting apart then... I didn't feel close to him as I used to...

Thus, in the first phase of the experience of postpartum depression the women who participated in this study felt a gradual loss of closeness in the relationships with

their partners. Whether the relationship was very close and strong before the birth or only somewhat close and “ok”, all the participants without exception felt that their relationship with their partners were being negatively affected by the situation and that a gradual distance has begun.

Summary of Phase 1: Becoming Lost

In this section the conditions that preceded the onset of depression have been presented. Following the birth of their babies, the women who participated in this study experienced denial of their physical and emotional needs to the extent that made them feel as if they did not exist as their own persons and were unimportant and neglected. Having to nurture and care for their babies/children without being cared for and nurtured themselves left them drained, empty and confused. The isolation and loneliness that they experienced, the help, support and guidance that they missed contributed to their sense of being at a loss or lost. Hand in hand with this process participants experienced a gradual distance from their partners who failed to provide them with the instrumental help and emotional support they needed and expected from them. As was evident in their stories, they rarely had a chance to communicate or have contact with other adults as well. It is considered common knowledge that interaction with other people is a privilege we all share as human beings that contributes to a person's emotional well - being. The women in this study were denied this privilege.

Becoming and being lost for a long time, up to 3 months, preceded the onset of depression. The longer the women spent in that phase and the more they felt they were lost, the more sudden and severe was the onset of their depression. The theoretical propositions that emerged from this phase are as follows: 1) The more a woman perceives

a denial of her physical needs the greater her chances are of becoming depressed following childbirth. 2) The more a woman perceives herself as being isolated the greater are her chances of becoming depressed following childbirth and 3) The more a woman perceives a denial of her emotional needs the greater are her chances of becoming depressed following childbirth. 4) The more a woman experiences a combination of self-denial and isolation rather than one or the other the greater are her chances of becoming depressed following childbirth.

Phase no. 2: Getting Trapped

Following 2-10 weeks of becoming and being lost there came a point in every participant's life where they were suddenly and overwhelmingly stricken by depression or in their words they "got trapped" by depression.

Figure 3 illustrates the relationship between the phase entitled Getting Trapped and the other phases of this model as well as the relationship between the various properties of this phase.

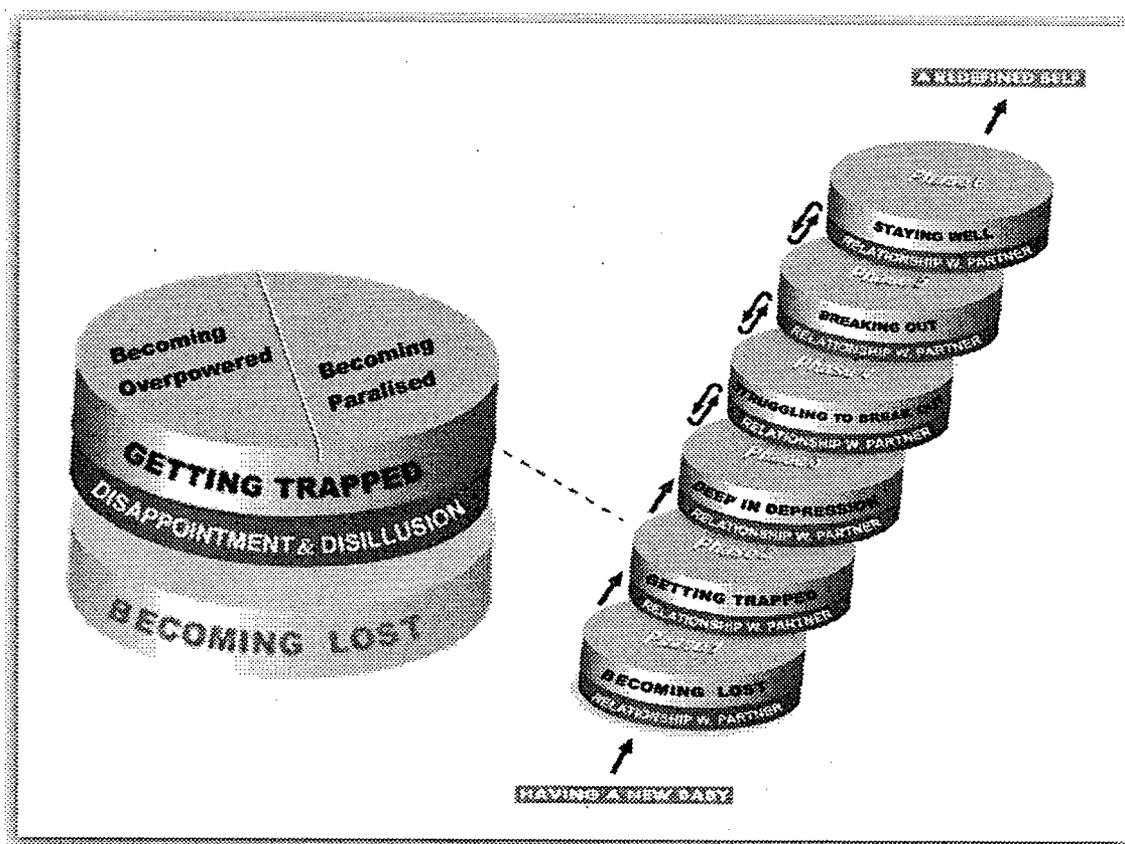


Figure 3. Getting Trapped. Phase no. 2 in the six-phase model of "The experience of postpartum depression".

As Figure 3 illustrates the conditions that were present in the former phase, Becoming Lost, remained present in the current phase. I.e., moving from the first to the second phase did not mean that the women stopped being isolated or denied of their

needs . Rather, the properties and conditions of the first phase provided the context for the current phase, i.e., they were still experiencing denial of self and isolation in the current phase.

Most of the participants who experienced exhaustion, isolation and a sense of loss of self during the first weeks following the birth described the onset of depression as sudden and surprising, even shocking. While struggling through these first weeks they did not expect to become severely depressed but rather they expected that they would keep on going the way they had been since the birth. They expected that they would somehow manage to cope. While few of them believed that things would get better, not even one expected things to get worse. When they were hit by depression they were overwhelmed, shocked and at a loss, as Barb recalled:

It was like you're walking alone in a forest and you're lost... you're really lost and it's dark and there's fog and you don't see any signs... you don't know whether you'll find your way out... you're really lost and you ARE scared but somehow you think you'll be fine and then... you suddenly get trapped like in an animal... like in a bear trap or something and you're in pain and you can't move and you can't do anything about it.

At the time they got depressed participants perceived their depression to have come out of nowhere and with no obvious or known reason. Only in hindsight did they believe that their situation before the onset of depression had caused them to get hit, or get trapped by it as Lila pointed out:

At the time I didn't think about it. But now that I look back on it I'm just wondering... I'm wondering if all that exhaustion and going on and on and on without a break didn't contribute to it... in fact I'm pretty sure it did.

Two main properties characterised the phase of Getting Trapped: one was Becoming Overpowered and the other was Becoming Paralysed.

Becoming Overpowered

The women in this study experienced depression as a power that imposed itself on them in a very sudden and aggressive way. Depression was perceived as an evil force that not only unexpectedly and abruptly imposed itself on them but also trapped the women. It gripped and confined them and they felt they could not escape from it. Depression seemed like a powerful force, which left the women feeling weak, as Cynthia remembered:

It was unbelievable... I'd never felt like this in my whole life... I couldn't do anything... I felt like a little kid having to fight a giant or a dragon... it was so strong...

Two conditions were present here. The first had to do with the sudden onset of depression and the second-with the enormous power of depression.

Being Suddenly Hit by Depression

The women's perception was that the onset of depression was sudden and unexpected. Despite being exhausted and feeling lost in the weeks prior to the onset of depression, participants did not expect the depression to come upon them as Karen described:

It seemed to come upon me... not gradual at all; it seemed as if I was ok one day then all of a sudden fell apart the next day.

Similarly Mary experienced a sudden onset of depression after weeks of exhaustion and feeling at a loss as she recalled:

I said to myself I had to carry on and so... I was going like this for a long time, weeks maybe. I thought I was ok. And then Bang! I just totally fell apart. It was unbelievable... I didn't know what'd hit me.

Nelly also thought she was doing ok under the circumstances until one morning she was surprised to find out she was not ok at all:

I seemed fine... I mean I thought I was fine considering... like I didn't get any sleep and I was totally overwhelmed with the baby and everything but I thought that it was normal, right? And then one morning I just couldn't get out of bed. I was a complete wreck and I totally didn't expect it.

Jody also described her surprise and shock as she was suddenly gripped by depression:

I couldn't believe this was happening to me. It was an awful feeling. I was completely shocked... I totally didn't expect it.

Despite weeks of being exhausted, physically and emotionally drained and desperately needing a break, participants were completely taken by surprise by the onset of depression and were shocked to find themselves in this situation. At the time they did not see a connection between feeling lost and the onset of depression. Once they experienced the onset of depression they realised that its force was fierce and mighty and much greater than their own.

Facing the power of depression

Participants described depression as an extremely powerful and evil force. It had the power to trap them, grip them and hold them captive.

For Laura, depression was a force that pulled her down and threatened to drown and kill her:

It was horrible. It was like you're trying to swim but something is pulling you down and down and down and you can't breathe anymore and it won't leave you alone and every time you're even trying to come up for air it just grabs you by your feet and pulls you further and further down 'till you're out of breath.

Alicia felt that her depression had the power to blind her. She said: "Depression covered me like a shroud – I couldn't see and I couldn't get out". Similarly Sharon said: "It was like a blanket that was dropped over me and I couldn't do anything about it".

The images of depression that the women used portrayed it as a powerful and persistent force that captured them and would not let go. In Helen's mind depression did not have a particular shape or form but its evil nature and great power was clear enough to her:

It was sitting on me, choking me... I couldn't think... I couldn't eat or even breathe. I was totally overwhelmed...

Thus, participants experienced depression as an extremely powerful and evil entity. It was almost as if they believed that the depression has intentionally captured them and was trying to smother or kill them. Their powerful images of depression illustrate the extent to which they were bewildered and overwhelmed by its power. Being taken by surprise and sensing depression's mighty grip, participants perceived themselves as being unable to do much about their situation. In other words, they became paralysed.

Becoming Paralysed

Having been suddenly caught by depression and facing its mighty and relentless power the women in this study felt trapped and overwhelmed. As a result they became paralysed and helpless, as Kelly recounted:

It gripped me so hard I couldn't move, I couldn't do anything, I was totally overwhelmed. Just totally and completely paralysed. I couldn't shake it off.

Among the participants there were those who, once being hit or captured by depression perceived themselves to be helpless and have not made any attempt to get out, and there were those who initially fought and tried to escape, failed and then gave up.

Experiencing Helplessness

Once having been caught by depression most participants felt immediately paralysed and did not see a way out of the depression trap. They were so shocked and overwhelmed by it that they perceived themselves to be completely helpless. Karen described her shock and dismay at being hit by depression and at not being able to get out of it:

What really socked me was just the fact that I couldn't, for some reason get it together... I couldn't believe I was falling apart in this way because up until then I'd been very much in control of my life... but this was different... I just couldn't do anything about it... I was completely out of control... completely and utterly paralysed.

Nelly used the common image of the tunnel, but for her, the tunnel was a trap you could not get out of and therefore had no point in trying:

Maybe it's as they say, like being in a tunnel. Except usually when you're in a tunnel you're moving forward toward the end, toward the light. But here, it was a tunnel where you couldn't move forward, or backwards, or anywhere. You were just there and it's dark and cold and you don't even know which way you should be going and even if you knew you couldn't because you were trapped.

Celeste had a similar experience to that of Karen and Nelly:

I was completely at a loss. I didn't know what to do and I didn't have the energy to do anything anyhow. I was a prisoner and there was no escape.

While most of the women in this study felt paralysed and helpless in the face of depression from the beginning, a few of them tried to fight and escape its grip - but failed.

Failing to escape

Participants who did not experience complete paralysis with the onset of depression sometimes made attempts to fight it and escape its grip. At first they believed

that they would be able to do that but soon enough they found these attempts futile and frustrating as described by Jody:

You felt like you were suddenly caught... trapped. And like those poor animals the more you fought the more trapped you became so you realised there's no point... there's no way out.

Patsy tried using motivational self-talk, thinking it was going to help her get rid of her depression but as she explained, it had been unhelpful to her:

I remember thinking, you know, I've got to get my act together, I have to get through this. I have a responsibility to my kids... I can't just fall apart and give in like this... there must be a way out of this. But I didn't really know what else to do and the depression just went on and on.

Mary believed that her being home with the children all the time was the cause of her depression. She therefore decided to go back to work shortly after the onset of her depression. However, while she felt somewhat better at work she would get depressed and anxious on her way home from work:

Already on the way home I could feel it. The depression, this down, unbelievable... terrible feeling creeping on me and I was just driving home feeling worse and worse... and so I thought 'what's the point. I'm not spending all my time with the kids but I'm not getting any better' so I quit... and then I thought 'there's nothing you can do about it'.

Whether the women tried to fight and escape the depression or just gave up fighting from the very beginning, they all ended up feeling paralysed and believing they had no power to change the way they were feeling. They believed it was their fate to be depressed and that they could not help themselves in any way.

The Relationship with the Partner: Disappointment and Disillusion

During the second phase of the experience when women felt they have become trapped and paralysed by depression they often turned to their partners for help. The

partner was often the only person the women approached for help; they were the only other adults that the women saw every day and the only person they were willing to reveal at least some of their distress to. Lila remembered how she believed her partner would save her from the scary situation she was in:

I remember thinking like 'he's got to help me – he's gotta do something about it' I was asking him for help I was falling apart and I needed him to help me... get me out of this... do something... I always used to look up to him for support...

However, like other participants Lila realised her husband was not able or ready to offer her the kind of help she needed – he could not be her saviour. Lila went on to describe her disappointment and disillusion with her partner:

He didn't know what to do even if he wanted to... he was busy at work and had other things on his mind. He just wanted me to be ok. To come back from work and find a happy wife, happy baby, a tidy house and a 3 course dinner... I was totally disappointed with him... I always thought I could count on him and I suddenly realised I was wrong... very wrong...

Similarly Cynthia described her disappointment at the kind of help her partner was able to offer her:

He was useless... absolutely useless... he would come home, see me all exhausted and upset and he would be mad at me for not being happy 'what's the matter with you?' 'What's wrong with you?' all I wanted was some encouragement... some recognition and yes, a little bit of help too but I realised I was on my own... he wasn't gonna help me...

The expectations that participants had that their partners would help them followed by their disappointment and disillusion played into the women's sense of emotional isolation. Having to face depression on their own, realising that their partners were not going to save them from their dire situation intensified the emotional distance that the women started to experience in the first phase.

Summary of Phase 2: Getting Trapped

The women who participated in this study experienced the onset of depression as a sudden attack, by which they were trapped by an evil and powerful force that gripped them and would not let them go. The participants were surprised and shocked by depression and were overwhelmed by its power and its ability to control their lives. Whereas most participants became paralysed immediately upon becoming depressed, a few tried to fight back and escape the trap. All of them, however, ended up feeling helpless and paralysed.

While each participant had her own unique image of depression, the image that emerged from all of these descriptions is of depression as a powerful, evil and persistent force. The women perceived themselves to be trapped without being able to escape, which made them feel helpless and hopeless. The women relied on their partners and hoped they would help them. However, they were disappointed and disillusioned by the partners' inability to provide them with the kind of support they needed and rescue them, which again, played into their sense of complete isolation. This led to the participants sinking further and further down into the depth of depression.

The propositions that emerged from this phase were as follows: 1) The more a woman perceives herself to be helpless the more severe she would experience her depression to be. 2) The more a woman perceives her partner as unsupportive the greater she would perceive her depression would be. A mediating variable will be the woman's sense of isolation.

Phase no. 3: Deep in Depression

Once participants got hit by depression and could not escape, they became paralysed and did not fight to get out of it. Following getting trapped by depression the women went through a prolonged period of time where they were immersed in the overwhelming power of depression. The interrelationships between this phase and the rest of the phases in this model are illustrated in figure 4 that also depicts the relationship among the various properties of this phase.

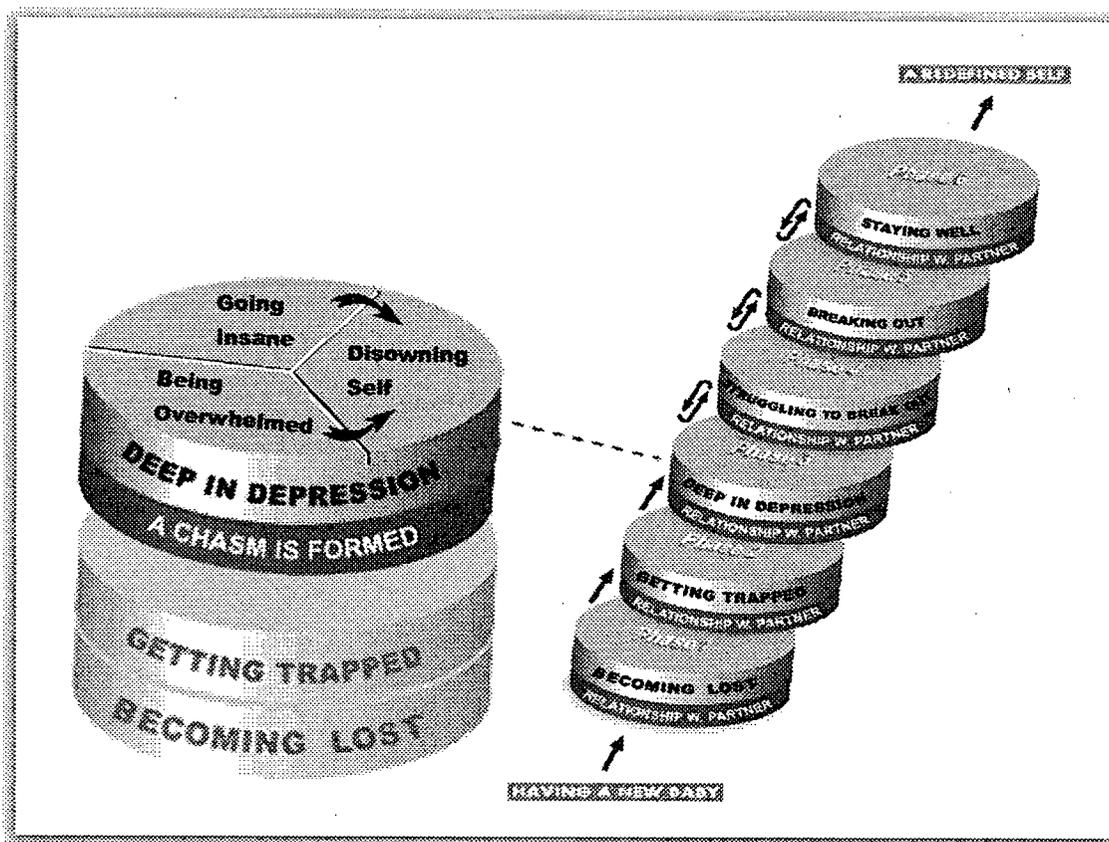


Figure 4. Deep in Depression. Phase no. 3 in the six-phases model of "The Experience of Postpartum Depression".

As figure 4 illustrates, the properties that characterised the first and second phase of this model were still apparent in the third one to some extent. The properties of the third phase have been identified as follows: 1) Being Overwhelmed by Depression 2)

Going Insane and, 3) Disowning One's Self. As illustrated by the arrows in this figure, properties number one and two preceded property number 3 and one of the hypotheses of this model is that the first two properties may be the cause of the third one. I.e., that because the women experienced being overwhelmed and insane they ended up disowning themselves. Also, the more they were overwhelmed and believed they were going insane the more pronounced was the participants' self-disowning.

The phase of being deep in depression lasted from 8 weeks up to about one year. During this phase the women experienced ongoing and relentless severe depression. Celeste was mildly depressed following the birth of her first child but became severely depressed following the birth of her second child:

It went on for almost a year... I remember Sam just had his first birthday when I was starting to feel a bit better... it started soon after the birth, maybe three or four weeks. I was so depressed I cried all the time, I couldn't get out of bed... I was so miserable... and the anxiety... I had this unbelievable anxiety that came out of nowhere... and these awful thoughts I was having... I thought I must be going crazy...

As is evident from Celeste's testimony the women who got to this phase were totally overwhelmed. In this phase they experience the myriad of symptoms of depression in a very powerful way. They described this phase of the experience to have been the most difficult one for them.

Giving in to Depression

Participants became completely immersed in depression at this phase; nothing else mattered to them and they were almost oblivious to other people and other things that were going on outside of their immediate environment. When talking about this phase of the depression participants described feeling constantly overwhelmed, functioning poorly and being hopeless.

Being Overwhelmed

The women in this study often referred to themselves as being easily overwhelmed by little things and often feeling overwhelmed for no apparent reason. Sharon remembered how she would get overwhelmed in the morning, when she was home alone with her two children:

I remember... Peter would leave for work and I'd be so heavy in bed and I carried the kids around and I'd be so overwhelmed to just even hearing their voices because I knew they would start demanding something from me. I was overwhelmed by that...

Sharon went on to give a typical example:

I might be sitting at the kitchen table and my daughter is there... she's dumped out on the floor... with materials on the floor and having to get up and deal with that felt insurmountable... just getting up to do that was so overwhelming. I was just so exhausted and overwhelmed all the time...

Like Sharon, Patsy felt overwhelmed whenever she had to perform even the smallest task:

It was so hard. I mean every little thing seemed like a mountain to me... even if it was just 'I have to read my daughter a story 'cause she's bored out her head' or I'd have to change a diaper... I would feel overwhelmed just by the thought I had to do this or that.

Mary remembered how she would suddenly become overwhelmed without an obvious reason at that moment, but rather because of the cumulative effect of having to deal with everything on her own:

I had to take care of two babies basically and I could barely open my eyes... and Sometimes I'd just sit there and stare, I wouldn't know what to do... it'll all kind of overcome me and I'd be at a loss...

Dianne found that things that she used to like doing and that she would accomplish quickly were now too big a project for her to undertake:

I used to like baking... I still do but when I was in the deep end of the depression just the thought of starting with it... it was too much... and I'd see... in my mind I'd see all the things on the counter and I'd just shudder... even the thought of baking was overwhelming...

When their depression was severe, the women in this study were easily overwhelmed by even the smallest chore, like changing a diaper. They found that little things and even things they had previously liked doing were now too overwhelming to even entertain in their thoughts. Another condition that went hand in hand with being overwhelmed was poor functioning.

Functioning Poorly

When looking back on the time when they were severely depressed participants remembered how poor their daily functioning had been compared to their pre-birth functioning or the way they had been functioning ever since they came out of postpartum depression. When discussing daily functioning most women referred to household chores and child – care tasks as Lila described:

At that time I couldn't do anything... I was exhausted all the time and I would be in bed most of the day and just get up when I absolutely had to, like when my daughter was crying or when I had to feed her. I didn't do the laundry, not to mention cooking. My partner was very miserable (laughs) but I just couldn't help it.

Patsy's depression also made her stay in bed a lot. She recalled how she could not take good care of the children and how her house used to look like during that time:

A lot of the time I just couldn't get out of bed... and my kids, you know Jared was still a baby so I'd have him in the crib crying and I'd ask Shay to... do something that he was occupied, lock all the doors so he couldn't get out and I'd just lie in bed and cry. And just cry and cry and cry and cry. And I couldn't... I felt like I couldn't do anything. My house was just a complete mess, like it was a bomb scare...

When Karen realised she was functioning very poorly she felt embarrassed. She kept comparing herself to her highly functioning mother-in-law:

I remember... in the mornings just not being able to get out of bed ... I just felt that I couldn't cope. And I remember feeling very embarrassed and very inadequate because my mother-in-law had 4 kids and she was one of those Sterling mothers that cooks 10 dishes and keeps a spotless house and I just felt totally embarrassed... I couldn't cope with one child and she brought up four.

Laura whose functioning had also been impaired compared herself to one woman in her neighbourhood she used to see passing by her house:

I was... completely unable to function in my life... I remember I used to see someone... she would ride her bike by my house with her kids in their little wagon and I'd see her and I couldn't even get my kids dressed and walk to the corner store.

Cynthia recalled how she used to do the bare minimum to keep her children's basic needs met, but did not have the energy to do anything beyond that:

Jessie was only a year old when Brian was born... she was just a baby and I'd just put the video on and put her in the playpen... give her a bottle or something and that's it. I didn't really spend time with her, I didn't read to her or played with her like I used to and poor Brian, I was just nursing him and changing his diaper and he'd be in his crib for hours and hours... I just did the bare minimum... I wasn't functioning.

When they were deeply and severely depressed the women in this study were unable to cope and function in their usual level. While they were not neglecting the physical needs of their babies and children, their children's other needs and their homes were disregarded for lack of physical and emotional energy.

Losing Hope

During the months of being in the depth of depression, when participants had not experienced any improvement in their mood and functioning for a long time, they began to lose hope of ever getting better. They came to believe that they were doomed to being depressed, anxious and overwhelmed all the time and that they would never be able to pull themselves together and function as they had used to, as Barb recounted:

I remember moving into this dark space where I was becoming completely hopeless. In the beginning I used to ask myself 'when is this all gonna end' but then later on I'd just say to myself 'this is never going to end... it's hopeless...'

While Helen was also being somewhat hopeful in the beginning she lost hope later on in the process as time went by:

I was getting to a point where I was totally overwhelmed and couldn't see a way out. I was feeling awful... just awful all the time and I didn't believe things would get better anymore 'cause you see, in the first couple of weeks I still thought it would go away on its own but then I completely didn't believe I would actually... not even laugh again... I wasn't even hoping to feel happy but just to not feel so awful all the time.

Patsy remembered being hopeless for many months and then becoming even more hopeless when her son had his first birthday:

I remember Jared's first birthday... I remember that being a real milestone for me thinking oh my God, he's a year old and I don't feel any better and I feel like this whole year has been a blur, a complete blur... I was just fried, burnt right out I had nothing left to give and I just, at that point I just hit rock bottom and I said 'I haven't gotten any better and I won't get any better and that's when I seriously thought about killing myself.'

Following almost a whole year of being depressed, Patsy started seriously thinking about killing herself. Like Patsy, other participants were losing hope of ever getting better. In

fact, most of them believed that not only they were not getting better but that they were becoming hopelessly insane.

Going Insane

At a certain point in the process of having PPD participants in this study believed they were gradually but steadily losing their sanity, or as most of them expressed it: they felt they were “going crazy”. Mary remembered her experience of being severely depressed:

... You feel like you're honestly going crazy, your mind is playing tricks on you and you have no control over it.

The meaning of Going Insane for these women was that they perceived different experiences they were having as bizarre, scary, troubling and very different from their usual experience of themselves. Moreover, they judged them to be generally abnormal i.e., most people would not have these kinds of experiences. The conditions that brought about the sense of going insane were the following three: having thoughts of harming the baby/children, having suicidal thoughts and experiencing anxiety and panic.

Thoughts of Harming the Baby/Children

One of the most troubling and alarming conditions of the experience of going insane was having thoughts and visions of harming one's baby or children. The women described these thoughts and visions as disturbing, penetrating, obsessive, horrifying and uncontrollable. The thoughts and images were very detailed and vivid. They usually consisted of an imaginary scene of the baby or child dying a horrifying death caused by the mother. In her mind the mother would either see how she is inflicting the harm upon

her child or merely know that it was her who had done it. Patsy described the disturbing images that were constantly haunting her:

I kept having these horrible thoughts, which I told no one about 'cause they scared the hell out of me. Like I was having thoughts of putting (child) in boiling water. As soon as I was cooking supper that's what I'd see in this pot and I'd picture putting him in there, and his skin peeling off, and him looking at me with his eyes just screaming help me, help me, help me!

Sharon described how after she delivered her second baby, her thoughts were a complete contradiction to her partner's feelings of joy when he came to visit her at the hospital:

I remember my partner coming in and he was so happy, he was just this happy Dad and... to have a baby boy... saying that this is the perfect family... a boy and a girl... and in my head I thought that I was going to kill one of them and we won't get a perfect family.... This was shooting through my head. It was really scary because I thought that that meant that it was true... that I was really gonna do it.

The women were alarmed and shaken by these thoughts and images, which were completely alien to any previous experience they had had. They believed that this experience meant that they were losing their minds. As Jody remembered asking herself: *What sane mother would even entertain a thought of harming her own child?* Also, as they would fail to get the terrifying thoughts out of their minds, despite desperately trying, they felt that the thoughts were controlling them rather than them being able to control their thoughts. This inability to control the disturbing thoughts and images was perceived by the women as another sign of insanity.

Ruth's description of her experience demonstrates the way thoughts and images controlled the women's minds:

I got it in my head that I was going to be one of those Moms that kills their babies... it was more than a fear... it was like I was obsessed... it was just this obsessed kind of thought that I would be that person who would do it and that there was no way to escape it.

Some participants, like Ruth, experienced these types of thoughts both during pregnancy and following the birth. Others experienced these types of thoughts only during pregnancy. However, most of the participants in this study experienced these troubling thoughts and images only after the birth, as Helen recalled:

I was totally shocked and horrified by these thoughts. I mean I was doing fine during the pregnancy... there were no warning signs at all but then I started thinking... and seeing these horrifying images of me killing my son... it was oh, so terrible! If I was working in the kitchen I would suddenly see myself cutting his throat with a kitchen knife and him bleeding to death on the kitchen counter I mean... I don't want to even go back there... it was just beyond belief!

This disturbing image was but one that Helen, like other participants, experienced over and over again. Like Helen, Barb also used to get these types of images while she was doing something in the kitchen:

I saw myself putting (child) in the oven... and he would just bake there and become brown and his blue eyes were staring at me... with his mouth open and he's like 'how could you do this to me, Mom?' It was monstrous, how could I be having these thoughts? It was killing me... just killing me!

Other participants had images of killing their babies with a knife, driving their car into a ditch killing both themselves and the baby. Also, throwing the baby down from a high place like a high-rise building or a mountain, strangling them by putting a pillow over their heads and drowning them in the bathtub.

The thoughts and images were causing participants to feel very uneasy about themselves. Some started seeing themselves as monstrous. However, as much and as hard as the women tried to get these thoughts and images out of their minds, they were unable to do so. Laura described her exasperation at being unable to get rid of the thoughts:

I couldn't get them out of my mind... I remember feeling like 'I just want to go, get out, get out, get them out of my mind but I couldn't and I tried, I desperately tried to busy myself with things, to walk away from the situation... anything that would help stop that! It was useless... useless. It just haunted me...

The recurrent thoughts and images terrified the women not only because they were very disturbing in themselves and were a sign of their insanity, but also because they believed they might be acting on them in the future. The participants were afraid that just like they could not control their thoughts and images, there might come a moment when they would not be able to control their behavior and will actually harm their children. Their fear that this might actually happen, that they were actually going to act on their thoughts tormented the women, as Alicia recounted:

I was terrified I wouldn't be able to control myself and that it'll get directed toward my children. That's what I was afraid of. I didn't give a shit what I did to myself but I was really frightened that I was gonna lose it... that I was gonna become one of those horrible front pages on the Province newspaper. That I was going to be some horrible tragic story that you see in the paper and you think to yourself: 'oh my god, how could this woman possibly do that?'

One of the most disturbing parts of the experience of depression if not the most disturbing of them was the recurrence of obsessive thoughts and images of the participants harming their own children. As much as they tried participants could not eliminate these thoughts or even minimise their frequency. The participants were horrified by these thoughts and by the fact that they could not control them. They believed that these thoughts were indicative of their true monstrous nature.

The ongoing distress and constant struggle with depression and with the disturbing thoughts and images, was accompanied by bouts of severe anxiety and sometimes fully blown panic attacks.

Anxiety and Panic Attacks

Participants reported to have experienced frequent bouts of anxiety and/or fully blown panic attacks during the time of their depression. Asked to describe their anxiety

participants referred to times when they were experiencing extremely uncomfortable physical and emotional sensations all at the same time. The physical sensations included: sweating, racing heartbeat, stomach distress, shortness of breath and light-headedness. The emotional sensations included: being afraid of losing one's mind, being afraid of dying, feeling stifled, trapped, paralysed and overwhelmed. Jody's words echo those of other participants in describing the anxiety she had experienced:

I was having maybe three or four, sometimes five panic attacks a day. It was awful. I felt like I was gonna die... I couldn't breathe... it was oh, such a terrible, terrible feeling. I was so anxious all the time and I didn't even know why... I thought I was just losing my mind.

The participants were surprised by the anxiety. They could not understand why it was happening or what precipitated it. They were completely overcome and paralysed by it and dreaded the next time they would have it, as Sharon described:

I experienced unbelievable anxiety... it was almost like panic attacks that were like constant attacks and I was completely unable to function in my life... it was unbelievable... there was nothing I could do to make it go away and I knew... I always knew there was another one just around the corner... and I dreaded it...

The participants would not tell anyone about their anxiety because they did not know what caused it, were ashamed of it and were sure that their intense anxiety was another sign they were losing their sanity. When reflecting upon that time in their lives participants were both sad and sorry that their depression and anxiety prevented them from functioning as "good mothers", as Cynthia recalled:

I was so preoccupied and absorbed in whatever was going with me, that depression and terrible anxiety... how could I do a good job as a mother? I was just not doing my job with the baby... wasn't doing anything much at all... I mean I did feed her and did other stuff for her but I was barely functioning 'cause of this constant anxiety.

The experience of intense anxiety and sometimes fully blown panic attacks occurred in addition to the feelings of being overwhelmed by depression that participants had. The anxiety they felt scared them, made them think that they were losing their sanity and left them feeling helpless. The experience of anxiety and panic, combined with the horrifying thoughts and images of harming their children resulted in the women disowning themselves.

Disowning Self

As discussed above, participants attributed their disturbing thoughts and images to a flaw in their character. This flaw, they believed, had been hidden all of their lives and was now emerging from the depth of their flawed soul, driving them insane. They were scared to find the “horrible truth” about themselves that was in a complete contradiction to their previous experience of themselves. They felt guilty and were ashamed of their situation in general and were ashamed for having thoughts of harming their children in particular. They believed that these thoughts were revealing a hidden, terrible part of their personality that had been unknown to them before. In other words, they believed that the fact they were having these thoughts and images was indicative of a horrible dark part of their personality. A part they had not been aware of had no control over and that had made them monstrous and insane. They became afraid of themselves and experienced self-hate because of these beliefs. Jody’s words echo those of other participants, who started seeing themselves as evil and monstrous:

I was so ashamed and frightened of who I have become. It seemed like a wild aspect of my character that I had never seen before... and I was not acting it out but it was inside... I became someone I didn't know and didn't like... I was appalled! I became a monster who could harm her own children... her own children!

Alicia had similar feelings to those of Jody. She became convinced that she was unfit to be a mother, and she ended up deprecating herself:

I felt shame, guilt, fear and I thought I must be the worst person to have children. I was just not made for motherhood. I told myself: 'what on earth made you think you could be a mother?!'

As is evident in the quotes above, participants were ashamed and engaged in self-deprecation. They ended up hating themselves as well.

Experiencing shame

All of the study participants without exception experienced shame. They were ashamed of their situation and of themselves. They were ashamed of being depressed, of not being good mothers and of not being able to function. They would not disclose their situation to anyone, even close family and friends because to them, their situation was very shameful and they dreaded being uncovered, as Sharon described:

I couldn't really go get support form friends because I couldn't really let them know it was happening...I thought a lot about what people would say if somehow it would be found out that I'm not a good mother...I so desperately wanted to be a good Mom and I was ashamed of myself for not being able to pull it together...

Patsy who had worked as a health – care professional in her own community was ashamed of her depression and therefore avoided telling people about it. Her worst nightmare was that her fellow – workers or other people in her community would find out about her depression:

I realised that I needed help but I didn't want to go to anybody in my community 'cause I didn't want anybody who could possibly know me to find out that I was feeling this way.

Patsy went on to explain why she did not confide in anybody while she had been depressed:

I wouldn't open up to anybody, you know not one of my friends, my mother or my partner... I wouldn't tell anybody because I thought of it as a personal failure and I thought they would see it the same way.

Kelly was also ashamed of her depression, but even more than that, she was ashamed for not feeling the joy of motherhood that she believed she was supposed to feel:

I kept telling myself 'what's wrong with you? Why can't you enjoy the baby? Why can't you enjoy being a mother? I was so ashamed of not being happy with the baby...

Celeste was ashamed of not being able to handle and soothe her baby:

She was crying all the time and I would try everything I could think of but I was never able to soothe her... she would fall asleep only in my partner's hands and I was really embarrassed by that... I was ashamed because I thought I must be a terrible Mom if I can't handle my baby...

Apart from being ashamed the women in this study blamed themselves for their depression and inability to cope.

Self-Blame

Participants perceived depression to have imposed itself on them, have trapped them and to have been extremely powerful. At the same time they blamed themselves for being depressed, and for not fighting depression and for not being able to cope. Like Alicia described, they felt that the root of depression had been residing in them all along and that it was their fault to have had it:

I felt like it had been my fault. I felt there was something fundamentally wrong with me. I wasn't cut out for motherhood.

Looking back on her experience Sharon commented on her inability to see what contributed to her depression in her environment and thus had blamed herself for it:

I was totally thinking this is my fault. I'm a failure... why am I not coping? I kept thinking of it as a personal failure. I wasn't getting any breaks but I couldn't see that this was happening, so for me I'm just a terrible mother not that I needed to take a break...

Much like Sharon, Karen did make the connection between her ongoing exhaustion and her depression and kept blaming herself for being depressed:

It was basically sheer exhaustion. I wasn't getting much sleep at all because by the time I'd fall asleep the baby would wake up for its next feeding. So I probably was surviving on 2 or 3 hours of sleep for months, which I think would push anybody to depression... But at that time I was just blaming myself... blaming myself for not being able to hang in there and pull it off... I just didn't see the connection...

Being constantly depressed, not being able to function, having horrifying thoughts of harming their children and blaming themselves for all of that eventually drove the women to self-hatred.

Self-Hatred

Participants describe how as a result of their experience of themselves through depression they grew to dislike and even hate themselves, as Nelly recounted:

I couldn't stand myself the way I was... such a good-for-nothing, crazy woman... and a lousy Mom, a lousy wife... I just hated it. I was constantly being hard on myself and I was just so fed up with myself... I was totally unforgiving... I hated myself.

Mary hated herself mainly because she believed she was not being "a good Mom":

I was constantly kicking myself about this whole thing. I wasn't being a good Mom... not at all... I wasn't remotely like what you'd expect of a mother and I used to say to myself 'how dared you even think that you could be a good Mom! You're so screwed up... look at you - you're good for nothing... a lunatic!

Similarly Sharon hated herself for being depressed and short – tempered all the time. Here she described how she felt following snapping at her daughter:

My daughter would do something and I would be screaming at her and felt horrified at myself for yelling at her and I would feel just so terrible about myself... I hated myself for doing that...

Helen's self-hatred was very general. She described her self-hatred as a gradual process, whereby, the longer and the more serious her symptoms of depression were - the more she hated herself:

I just hated myself more and more... 'cause you know, in the beginning I felt sorry for myself for feeling the way I did. But the more depressed I became, and the more I had thoughts of harming my child – the more I hated myself. I couldn't stand who I have become...

Thus, the women in this study grew to hate themselves because of the way they had felt and acted while being depressed. As is evident from the women's stories, their self-hatred was a result of being ashamed of having obsessive thoughts of harming their children, their poor functioning and their anxiety and depression.

Suicidal Thoughts

Participants whose depression lingered for many months and who had disturbing thoughts and images of harming their babies/children and anxiety attacks grew to disown themselves. As well, they often experienced suicidal thoughts in varying degrees of intensity. Some of the women thought of suicide as a way to avoid hurting their children, if they ever lost control. Others contemplated killing themselves as a way to end their suffering, or as a way to get a break and a rest from their unbearable situation. Yet others believed that by killing themselves they would be helping their children to get better care than they themselves were able to provide. For some participants it was a combination of

the above. In general, suicide became a conceivable solution to the participants' unbearable situation once they have given up hope to come out of depression.

Alicia, who had been having recurrent thoughts about hurting her children, planned to kill herself in order to spare her children, and especially her baby:

I was having those terrible... horrible images of hurting my kids...especially the little guy. I don't know why but... Oh, it was so awful and I was terrified that one day I would do something... I would go completely crazy and... and so I thought I'd better kill myself first, I'd rather do it to myself than do it to them.

Sharon experienced guilt feelings due to her thoughts and images of hurting her children. She was afraid that one day she would act upon these thoughts and hurt her children. As was true for other participants, having obsessive thoughts and anxiety brought about suicidal thoughts for Sharon. Like some of the other participants, when Sharon started to have suicidal thoughts she would dismiss them, saying to herself she could not do it because of her children; she would not leave her children without their mother. However, as her depression worsened she started to believe that her children would be better off without her and that someone else would be able to do a better job than she had been doing. Thus, she contemplated killing herself not only in order to get relief from her misery, but also to give her children a chance of getting the care they deserved as she explained:

... It got where I felt so bad about myself that I remember it progressing from 'I couldn't do that to my kids they had to have their mother' to moving into 'they'd be better off... at least they'd have a chance to have another mother if I wasn't here. Yes they'd be upset but they'd get over it and someone would fill my shoes and they'd do a better job'.

Kelly thought of killing herself as a way to stop her ongoing suffering. Kelly's words describe the fantasy of suicide that many participants shared:

I thought how nice it would be to get in bed and put the blanket over my head and not hear anything and not feel anything and be quiet and peaceful... be in another place, another way and just be content. I didn't even think 'happy' I just wanted to be peaceful and content...to be left alone and never feel that way again.

The women experienced suicidal ideation on all levels of intensity. For some, there were just thoughts that crossed their minds a few times during the course of depression. Others had recurrent thoughts of suicide but no suicide plan. Yet others had recurrent thoughts accompanied by either a detailed or unspecific plan. Finally, there were those who actually attempted suicide.

Mary was depressed following the birth of her first child and again, more severely, following the birth of her second child. She did not receive any treatment in either one of the episodes. Mary had infrequent thoughts of killing herself as she described:

The depression was unbelievable... and once in a while I'm like 'oh my god, I can't take this much longer' and once or twice I thought I would drive my car into a ditch and get it over with.

Cynthia described how she used to have recurrent thoughts of killing herself that she would dismiss immediately, thinking of the welfare of her baby:

...I was like 'I can't take this anymore' ... the depression and being so lonely and everything and (baby) was crying and crying and crying and I would get so tired and miserable and... 'I can't go on like this, I can't stand another day like this'. And I'd say 'maybe I'll just shoot myself in the head or something and it'll all be over' but then I'd say 'poor baby, poor baby how can I do this to him?'

Patsy, whose depression became more severe after she had been dismissed as being 'stressed out' by a health-care professional, thought of suicide very often. Her plan was unspecific and changed from day to day and from one situation to another. This was the way Patsy described her changing thoughts about the issue of suicide:

I felt like I had nothing left to give and I think that's the time when I was... I never ever tried to kill myself or attempt suicide but man oh man I thought about it a lot, about how it was the only way I could make this feeling go away... I thought of driving my car into a ditch and drowning myself, or I would drive into a brick wall with my seatbelt off or you know I thought of slitting my wrists... and I thought of taking a whole bottle of pills and just never waking up.

Patsy went on to explain what kept her from acting on her suicidal thoughts:

I thought that [taking pills] would be an easy way to do it, but then I would always have thoughts of 'oh, my partner is never home so then the kids would have to be all day by themselves before he would come home and find me'. So I'm worrying about the kids. This is during all of this thinking 'well I can't do that because that would be hard for the kids.'

Like Patsy, Jody also experienced recurrent and penetrating thoughts about killing herself, but unlike Patsy, Jody had a well thought-out plan:

I saw it very clear in my mind. It would be one of the weekend days and I was going to ask Jack to take the baby away for a few hours so that I could get some sleep, maybe to his sister... and I... as soon as he left I would take the whole bottle of those sleeping pills that I had, and I'd just sleep and sleep and sleep... 'cause you see, I didn't really want to die, to be gone forever... but I just couldn't do it anymore. I was so exhausted I just didn't care about anything anymore. But somehow I didn't do it. I just couldn't make myself do it. I guess I was afraid that I would change my mind and it'd be too late.

Alicia, whose depression got worse with each one of her three pregnancies and deliveries, had recurrent and very frequent thoughts of suicide. Her depression got deeper and deeper and she was left without a shred of hope. She refers to herself as having been "extremely lonely" and "desperate". For many months Alicia tried to do her best taking care of her children while struggling with severe depression and having recurrent thoughts about hurting her children. Here, she described how she ended up attempting suicide:

I could feel it crashing down on me-this depression was unbelievable... and I said: 'I just want to get over Christmas' and so on December 27 I was given a container of Ativan to be able to sleep because I had a lot of anxiety. I had anxiety attacks every day, at least once a day. So one evening I was standing in the

bathroom and it all became just too much for me. I just couldn't take it anymore. I had gone as far as I could go and I just gave up and took the whole container of Ativan. I didn't want to commit suicide. I wasn't trying to kill myself. I was just so exhausted, so tired and worn out and sick of fighting... of everything. And I just couldn't do it anymore. I just wanted to be left alone; I just needed a break from everything.

Much like other participants Alicia did not really want to die. Rather, she desperately needed a break but sadly was unable to see any other way of getting what she needed in order to feel better. Luckily, her partner found her before it was too late.

The idea of suicide as a way of getting a break and putting an end to one's suffering was a common thread in the participants' stories. They stated very clearly that they did not really want to die and be gone forever, but that they were desperate for a break or a relief and could not find any other way of getting it. The longer the depression lasted, the more they thought about suicide as a solution. Their desperation was so great that they thought, contemplated or even attempted suicide as their only way out of their dire situation.

The thoughts and images of harming the baby or children, the thoughts about suicide and the experience of anxiety and panic all created a sense in the participants that they were losing their sanity or, as they put it, they were "going crazy". Participants believed that the process of becoming insane was completely beyond their control. Interestingly enough at the same time they believed that the seed of insanity had been residing in them for a long time unbeknownst to them. Thus they believed that their own personal flaw and failure to "pull themselves together" had caused their insanity and was entirely their fault. The sense of going insane combined with the experience of being overwhelmed by depression pushed the participants toward a state of self-disowning as described in the following section.

The Relationship with the Partner: A Chasm is Formed

During the time of being deep in depression the women experienced a pronounced emotional distancing from their partners. Most of them described this period of time as the darkest in their history as a couple. They felt so emotionally alienated from their partners that they did not see any way of getting closer again – they perceived an unbridgeable chasm between themselves and their partners. There was a lot of anger, resentment and lack of empathy in the couples' relationships at that time, which contributed to the sense of emotional alienation as Sharon described:

He was working these long days and he would walk in the door and I was screaming, yelling or maybe not saying anything at all but handing over the kids to him... I was not a very fun person to be around... I was so unhappy... and he was really being cold and started to be quite angry with me for not being ok... so I was angry at him for being angry at me. How can he be angry at me for not being well? ... he had sort of silent rages you know, clenched jaw and it got to the point where we were like strangers... except we had kids together...

Patsy remembered how her husband had distanced himself from her and from the home when her depression was at its worst:

My husband was working very long hours in the business... and the more I begged him to come home earlier... the more I asked him to help me the more he became resentful and started being away even more... if it wasn't work it was the horses and if it wasn't the horses it was his volunteer job... he just became totally unavailable as if this had nothing to do with him... I was falling apart and he didn't want to have anything to do with it...

Thus, when they were most desperate and vulnerable, participants experienced the most profound emotional distance from their spouses - the men they expected would be their source of support, their partners and their saviours. Looking back on that time, participants said they had believed that their relationships with their partners were damaged beyond repair and might dissolve in the future. That belief exacerbated their depression and made them angrier, which in turn alienated their partners even further. It

was a vicious cycle by which the relationship was adversely affected more and more over time.

Summary of Phase 3: Deep in Depression

This section discussed the third phase of the theoretical model of this study. This phase, entitled Deep in Depression, represents the core of the experience of postpartum depression as it emerged from the data of this study. In this phase participants were experiencing the symptoms of depression in a very profound way. After being hit or captured by depression, whether initially they tried to escape from it or not, participants ended up giving in to depression. They were overwhelmed by it, were functioning very poorly and were losing hope of ever getting better and going back to being fully-functioning content adults. Giving in to depression was happening concurrently with a process whereby the women believed they were going insane. This was due to disturbing obsessive thoughts and images they had of harming their babies or children, suicidal thoughts and anxiety and panic attacks. Finally, participants ended up disowning themselves. They were ashamed of themselves, blaming themselves for their situation and eventually hating themselves.

During this phase the women's relationships with their partners were the worst. The lack of understanding, the anger and the resentment exacerbated the emotional distance between participants and their partners to a point where the women believed the relationships were permanently damaged and the chasm unbridgeable. Their sense that the relationships might dissolve made their depression even worse. This phase was the longest of all the phases in this experience and lasted up to a whole year. During that time participants did not receive any professional help and very little help from family and

friends. However, there came a time in each woman's life when she was starting to try and break out of her depression.

The propositions that emerged from this phase were as follows:

1) The longer the depression lasts the more severe it becomes. 2) The longer the depression lasts the higher is a woman's suicide risk. 3) The longer the depression lasts the more chances she has of having obsessive thoughts and images about hurting her baby/children. 4) The higher a woman's level of anxiety the more she is at risk for self-disowning. 5) The more a woman has obsessive thoughts about hurting her baby/children the more she is at risk for self-disowning. 6) A combination of obsessive thoughts and anxiety will result in a higher chance for self-disowning than in cases where each of them exists on its own.

Phase no. 4: Struggling to Break Out

The phase in which participants made attempts to break out of depression emerged from the previous phase in which the participants experienced profound depression. The transition from the previous phase to the current one was not linear but cyclical. I.e., participants went back and forth between these two phases, often more than once. Moving from phase III to phase IV happened at different times and in different ways for different participants. Figure 5 illustrates the relationships between this phase and the other phases of the model, as well as the internal relationships among the different properties of this phase.

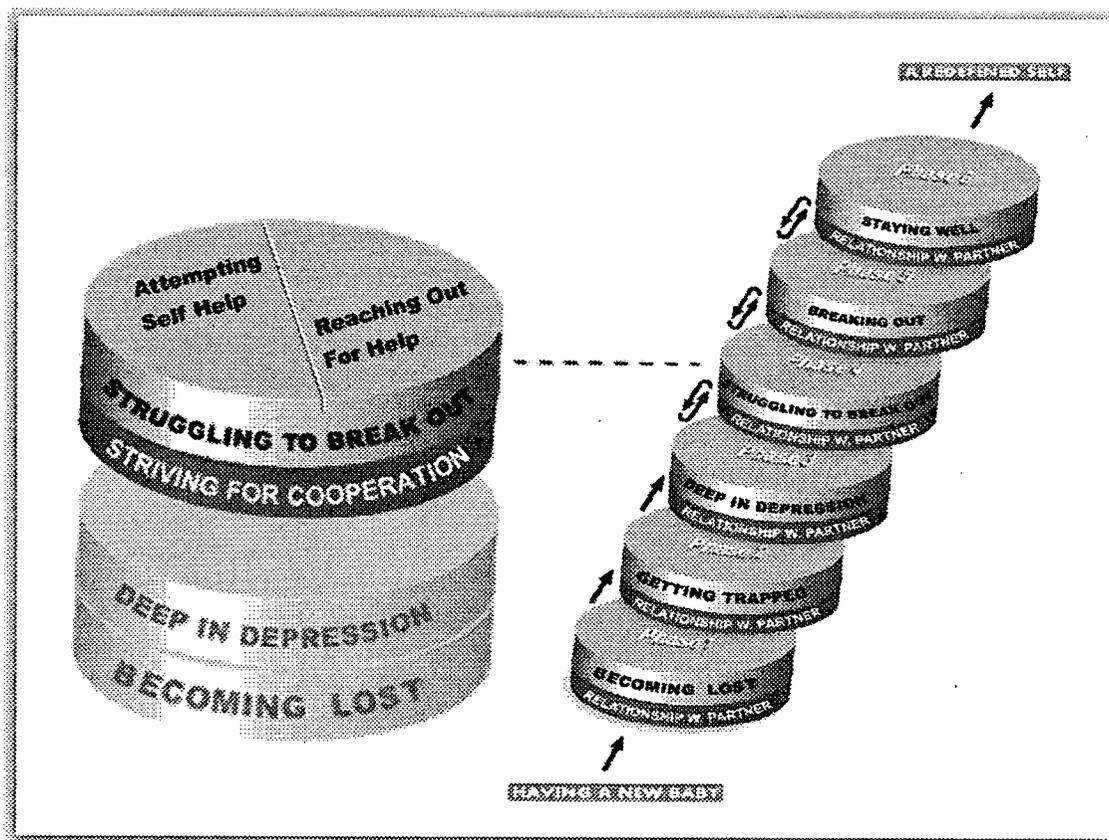


Figure 5. Struggling to Break Out. Phase no. 4 in the six-phase model of "The experience of postpartum depression".

As illustrated in figure 5 the two main properties of this phase were 1) Attempting Self-Help and 2) Reaching out for help. Some participants engaged in both simultaneously. Others engaged in one and then the other. All of them engaged in both eventually.

Attempting Self Help

Some of the participants made attempts at helping themselves to feel better. These were mostly the participants whose reluctance to seek help was the greatest. They were ashamed and afraid of being labelled and sanctioned by society. Some were afraid that their children would be taken away from them by the authorities due to their poor functioning. For example Jody recalled:

My worst nightmare was that someone would find out... and that they would report me to the ministry and they'd come and take Michelle away from me... I was just horrified at that thought so I just said 'you've got to pull yourself together before anything really bad happens'

Thus, participants ended up in a vicious cycle whereby they were severely depressed and dysfunctional but were too ashamed and afraid to seek help. With the lack of help their depression worsened which made them even more reluctant to seek outside help. Most of the participants tried to self-help at this point. A few participants attempted to engage in self – help in the following ways: one was to go out of the house and the other was meditating.

Going Out

The meaning of “going out” for the participants was to engage in some activity outside of the house without the baby. It meant that the women had to arrange for someone to take care of the baby while they were out. While most of them found it difficult to do they realised that they had to do something in order to feel better. Cynthia

described how after six months of being constantly home with the children she asked her partner to take care of them one evening a week:

I think I waited a week or more for the so-called right moment to ask him. I thought he wouldn't like the idea because Erin would sometimes cry and cry especially before bedtime. But one night I just asked him and I was actually surprised because he's like 'sure I'll do it'. Well, let me tell you... I couldn't believe my ears (laughs) and so I started going out with my friend Sheila and we would just go see a movie or have coffee or something...

Ruth once mentioned to a friend that she was tired of being home with the baby all the time. When the friend offered her help with baby-sitting Ruth decided to accept her friend's kind offer:

So I'm talking to Rebecca, she was just a friend... not a very close friend just someone I knew and I'm telling her I'm bored stiff and all that and so she says 'bring her over to here' and she's like 'I'd love to do it, really'... 'cause her daughter was 3 at that time and she was home so I signed up at the fitness centre and started exercising twice a week.

For some of the women going out meant either taking a course or working outside the home. For example, Ruth decided to go back to working part-time. As a computer analyst she had the option of taking on some projects while declining others:

Going back to work was like a breeze for me... I loved it... I felt human again. I was away from my baby for a couple of hours every day and it made a lot of difference... I felt I was accomplishing something... I was refreshed... I felt alive again.

Whereas some participants felt they had to go out of the house in order to feel better, others found that meditating in or out of the home was helpful to them.

Meditating

The women who engaged in meditation described it as quiet time when they were not performing any tasks but rather are simply relaxing somewhere on their own. Usually these women were used to meditating before the birth and had neglected doing that

following the birth due to their exhaustion and long list of things to do. They reached a phase, however, when they believed that meditation was important enough for them even if they had to postpone other activities. Helen remembered how at a certain point she decided to go back to meditating:

I used to meditate a lot before my baby was born and I liked it a lot... but after she was born I just didn't have the time because I was nursing her and she nursed like every 2 hours or so... but then when she was I think 6 or 8 months I told myself you've got to go back to meditating and I decided that once a day when she was napping that I would just do it and not use her nap time to do the laundry or the dishes like I'd used to...

The women who engaged in self-help activities found it to be somewhat helpful but it usually did not completely relieve their symptoms. Some of them reached out for help either before, after or at the same time they were attempting to self-help.

Reaching Out for Help

At this phase of the experience all of the participants in this study realised they needed some help. This usually happened after weeks or months of being severely depressed. For most participants there was an incident that drove them to the realisation they needed help, upon which they started the process of reaching out for help. Alicia was in so much emotional pain one day that she hurt herself by hitting her arm with a meat tenderiser. She did it hoping to get rid of her emotional pain by inflicting physical pain upon herself. She remembered how this incident prompted her to seek help:

I told my parents how my arm got bruised and they went "oh" and other people just looked at me but didn't say anything. But I knew 'come on girl, you've gotta get some help 'cause you're losing it big time'... it was a wake up call for me.

Like Alicia, most of the participants decided to seek professional help. Others chose to look for information about the postpartum period, hoping to find some answers and some help there. Some participants did both.

Looking for information

The experience of depression following birth was new to the overwhelming majority of participants. They sensed that something was seriously wrong with them but did not know what it was or why it happened and most of all, how to break out of their situation. They were therefore looking for answers in books, magazines, pamphlets and T.V. shows. Kelly remembered how she was reading any book that she could get that dealt with the postpartum period:

I was reading voraciously... looking for some answers... I thought 'there must be something written somewhere about this' but all I could find at the library were books on child – care and such and so I didn't really get any answers...

Laura was looking for answers in magazines but like Kelly, she did not get the information she so much needed:

I remember spending hours in book stores with Leslie in my lap going through all those parent magazines and such and I was looking for something... an article or something that would describe what was happening to me, but I remember reading an article about the postpartum period and all it said was that mothers don't get enough sleep and that you should try to nap while your baby does... I mean, I knew that but I felt it was way more serious than that...

Kelly and Laura, like some others, were looking for information but were unsuccessful in their attempt to get answers that would explain their situation. A few of the women were successful in finding an article, a book or even just a pamphlet that gave them reassurance that what they were experiencing was not unique to them. Alicia was visiting a paediatrician office with her son when she happened to see a pamphlet that had some information that was relevant to her:

One day I went to the doctor with my son and I saw a pamphlet of the Postpartum Support Society... and it was... I can't describe it... it was like an epiphany... everything came together and I said 'that's me'... I was in tears...

A few weeks after being dismissed by her doctor Lila decided to look for information in a big book - store. She described her reaction to the information she got by reading one particular book:

I said to myself 'there's got to be something written about this somewhere' so I went to this bookstore and asked the lady to show me all the books they had about birth and postpartum and she showed me a few and one of them... "should you... or shouldn't I be happy" and I couldn't believe my eyes... I was basically in tears all the time... reading parts of it in the store and just... oh, it was such a relief just to find I was not the only one...

At a certain point in the process participants were actively looking for information that could shed a light on their situation and give them some answers. Those who were unsuccessful in finding such information went back to feeling desperate and depressed for a while before they either tried looking for information again or sought professional help. Those who were successful in getting the relevant information usually took action shortly after. They either went to see a professional with the information at hand or looked for ways to make changes in their lives in hope that it would bring them the desired relief of symptoms.

Looking for Professional Help

Participants described a painful struggle they experienced before actually seeking help. On the one hand, they were extremely ashamed of their situation and afraid of people finding out that they were depressed. On the other hand they had reached a point where they realised they could not get better without professional help as they had tried to break out of depression without such help but had failed to do so.

Ruth described how she went on for weeks trying to gather enough courage to make an appointment with her doctor:

I was so ashamed and afraid of what the doctor might say or do... I knew I had to make that move but I couldn't... for weeks, or... maybe 2 months I would say to myself every night 'I'm making the call tomorrow' but the next day I'd be too afraid to do it...

Similarly Patsy was thinking of getting professional help following being depressed for about 10 months. For her, the turning point happened when her son was one year old and she realised it had been this long that she had not been well. Patsy remembered it took her a few good weeks before she found the courage in herself to actually go:

I heard there was a list of counsellors that you could go and see and I struggled with that in my mind for weeks and weeks thinking well maybe I should do that, maybe I should go talk to somebody ... but I didn't want anybody to know... to find out how I was feeling so I kept postponing it until eventually I did go.

When participants gathered enough courage to go and see a professional, the result was not always positive. Few of the participants saw a health care professional such as a physician, a nurse or a counsellor who diagnosed them as having postpartum depression and offered the appropriate care during their first visit. In most cases, however, the professionals who were consulted failed to make the right diagnosis, dismissed the women and either did not offer any help or offered inappropriate help. Nelly told her family physician that she was crying all the time was not sleeping or eating and that nothing she had done had helped her to get better. She recalled her doctor's reaction:

He said 'well, you know, you're a busy Mom, it's hard with two young kids and your partner's very busy so just try to get some sleep and you'll get better...'

Nelly's doctor failed to diagnose postpartum depression. He minimised her concerns and dismissed her. Similarly, when Cynthia sought help at the local health care centre and

described her symptoms to the professional who saw her, she failed to identify Cynthia's depression and offered her inappropriate help:

So finally I thought 'this is crazy' and I went and sought help at the mental health unit... and the nurse or whoever she was suggested assertiveness training (laughs)... well, I think assertiveness training is a good thing but it was way beyond that... I could not even think straight and I wasn't functioning... it was hard for me even to get to the health care unit to see them...

Sharon went to see her doctor more than once and used to cry in his office. She told him how down her mood had been, how she had been angry and miserable and that she had not been able to function. Her doctor, too, failed to diagnose her depression:

I was crying all the time, always in tears in his office and never ever did I hear from him that it was this kind of depression... he said I was gonna be ok he just kind of brushed it off...

The women in this study struggled with depression on their own for a long time and finally gathered enough energy and courage to reach out for help. They hoped that they were taking the right step and that it would lead to a solution to their problem. When they were dismissed and did not get the appropriate care they were devastated and their depression often worsened. Patsy described how she felt after her session with a counsellor who failed to offer the right help:

I left there just a wreck. I remember leaving feeling like 'I finally reached out to somebody and she just said 'no, I don't think it has anything to do with the baby' because my baby at that time was a year old... but I told her it's been happening all along and was just getting worse and worse... oh it was awful... because you know, you finally reach out to somebody and then... so I remember then going for a few more weeks and things were just awful and awful and awful...

Alicia believed that her obstetrician would be knowledgeable enough to help her and so she went to see her. However, like other participants she was disappointed and devastated when her doctor neither diagnosed her problem nor offered her help:

I tried to talk to my doctor... I thought she might know but she didn't know what was going on... she couldn't explain it or help me. I left her devastated. I felt guilty as if I must be lacking something within if my own doctor didn't know what the heck was wrong with me... I thought that if she didn't know what was going on I must be really screwed up...

Much like Alicia other participants were convinced that the health care provider could not help them because what they had was a rare condition that was rooted in a flaw of their character. Thus, they became devastated, hopeless and even more depressed following their visits to professional, who could not help them, as Helen described:

I was doing worse after this visit 'cause I just said 'there's nothing... nobody can help you... you're on your own in this shit...' and so I was really, really depressed... there was no hope...

Similarly Jody was feeling worse after she went to see a counsellor than before she did:

I remember feeling shattered... 'cause basically she said that I was just adjusting to my role as a mother and I thought 'I never saw anybody else... none of my friends was so depressed and they had babies too' so I was feeling really terrible and I think I completely lost hope then...

At this point participants often regressed to the previous phase, lost their hope and experienced the severe symptoms of depression as detailed in the previous section (Deep in Depression). Following the experience of reaching out and failing to get help, they stopped trying to connect with professionals. However, after a while, most of them tried to get help again. This process of going back and forth happened at least twice and up to four times with some participants until they finally either got diagnosed or self-diagnosed and got some help.

The Relationship with the Partner: Striving for Co-operation

During the fourth phase, when the women were desperately trying to break out of the depression, the women and their partners made some attempts to co-operate. In most of the couples these attempts were sporadic and inconsistent. Striving for co-operation meant that the women tried to recruit their partners to help them more with house-chores as well as when seeking information and professional help. Some of the men, on their part, tried to share more of the chores, give advice and seek information. Kelly remembered her plea for help from her partner and the effect it had on their relationship:

I was totally unable to cope with everything and... I asked him to help me more and I said 'you've got to help me or I don't know what's gonna happen...' so he did, for a couple weeks at least he put them to bed... he would give them a bath and stuff and that was big help...

Cynthia recalled how her husband had asked her to tell him about her visit to the doctor and how his reaction affected their relationship:

So that evening he asked me what the doctor said and I told him and I said 'basically she thinks I'm too tired...' so he said 'but everyone's tired... I'm tired too' and that made me really upset... But later he said 'well maybe we can take turns over the weekend so you'd get some more sleep' and just the fact that he finally acknowledged it made it better for me...

When Nelly was making her third attempt at getting professional help she asked her husband to join her for a counselling session. She described how she tried to get him involved:

I thought maybe I won't get dismissed so easily if he came along and he did, and it wasn't a great experience but at least he was there with me and we talked about it after... at least he showed some interest and that meant a lot to me.

Most women started to believe that they needed help and realised they had to be proactive seeking that help. The participants differed in the experiences they had looking for professional help as well as in their experiences of asking for their partners' co-

operation. The partners' willingness to co-operate varied greatly and ranged from being completely disinterested to being enthusiastic about helping and co-operating. Mary described her partner's indifference to her pleas for help:

He couldn't care less... to him it was all my fault... I wasn't doing my job, I was lazy... crazy... he didn't want to even come with me to see the doctor.... He basically said 'you have a problem – not me. Why should I see a doctor?'

A few partners, like Sharon's, were willing to co-operate and help, usually by performing more chores. She described how her husband started to co-operate and help more after a conjoint visit to the doctor:

He finally realised 'this is serious... this is not just complaining' and so he would come home at around six and... of course I didn't make dinner... he would put the baby on his back in the Snuggli and put some dinner together and after dinner he would go out and mow the lawn with him on his back...

Despite the sporadic attempts at achieving co-operation, there remained a pronounced emotional distance in the couples throughout this phase. Specifically, at this point there started to form two groups of couples: in the first group the partners demonstrated varying degrees of involvement and willingness to co-operate and in the second group the partners were reluctant to be involved and were perceived as non-co-operative by the women. However, even in the couples with the involved partner emotional distance, at least on the women's part remained great. This was due to the fact that despite some instrumental help that some partners offered, the women still felt emotionally unsupported by them.

Summary of Phase 4: Struggling to Break Out

Following weeks and sometimes months of being deeply depressed there came a point when participants started trying to break out of depression. For some, there was a specific incident or occasion that prompted this behavior, others simply reached a point where they could no longer tolerate the depression and had to take some action. In their attempts to break out of depression participants were looking for ways to help themselves as well as ways to get help from professionals, books and magazines. Some of the participants who looked for information were successful in finding some answers. Others were disappointed when they failed to find any books or magazine articles that were relevant to their experience.

The health care professionals who the women had turned to misdiagnosed and dismissed the overwhelming majority of them. They did not offer participants the appropriate and much needed care. This experience left participants disappointed and devastated and often pushed them back to being deeply depressed and hopeless. Many participants repeated the sequence of reaching out for professional help, being misdiagnosed and regressing to depression several times until they finally either diagnosed themselves or were diagnosed as having postpartum depression, which helped them to move into the next phase. During the time participants were trying to break out of the depression they also tried to recruit their partners to co-operate and help them more than they did before. Whereas some participants became more involved during this phase and worked toward more co-operation, others remained disinterested and uncooperative. Women whose partners were more involved experienced a slight improvement in the

emotional closeness with their partners. Women whose partners showed no interest remained emotionally distanced from their partners. However, even for the first group, there was merely a minimal improvement because of a feeling that these women shared of not being emotionally supported by their partners. All of the participants in this study eventually moved from trying to break out to actually breaking out of the depression. The length of time they spent in this phase was related to the length of time that elapsed before they either self-diagnosed or were diagnosed by a health-care professional. Whether or not their partners helped and co-operated with them had a slight effect on the degree of their perceived emotional closeness with their partners. Still, the most powerful aspect of this phase had to do with diagnosis and beginning treatment for PPD.

The following propositions emerged from this phase:

- 1) The earlier a woman is diagnosed with PPD the faster she may break out of depression, i.e., she will perceive a significant amelioration of symptoms.
- 2) Being dismissed and misdiagnosed by a health-care professional may worsen a woman's depression and a woman is at a greater suicide risk when she has been dismissed and misdiagnosed by a health-care professional.
- 3) The more negative the result of a woman's outreach for help is, the more reluctant she may be to seek further help.
- 4) A woman may regress in her course of depression following unsuccessful visits to a health-care professional.

- 5) Instrumental help without emotional support from a partner may not contribute to emotional closeness in the couple and thus may not help to alleviate a woman's depression.

Phase no. 5: Breaking Out

Participants struggled to break out of depression for different lengths of time, taking various actions as discussed in the previous section. By engaging in these actions participants pushed themselves toward the next phase on the road to recovery that has been titled Breaking Out. Figure 6 illustrates the relationship between the current phase and the other phases in the model. It also depicts the internal relationship between the phase's properties.

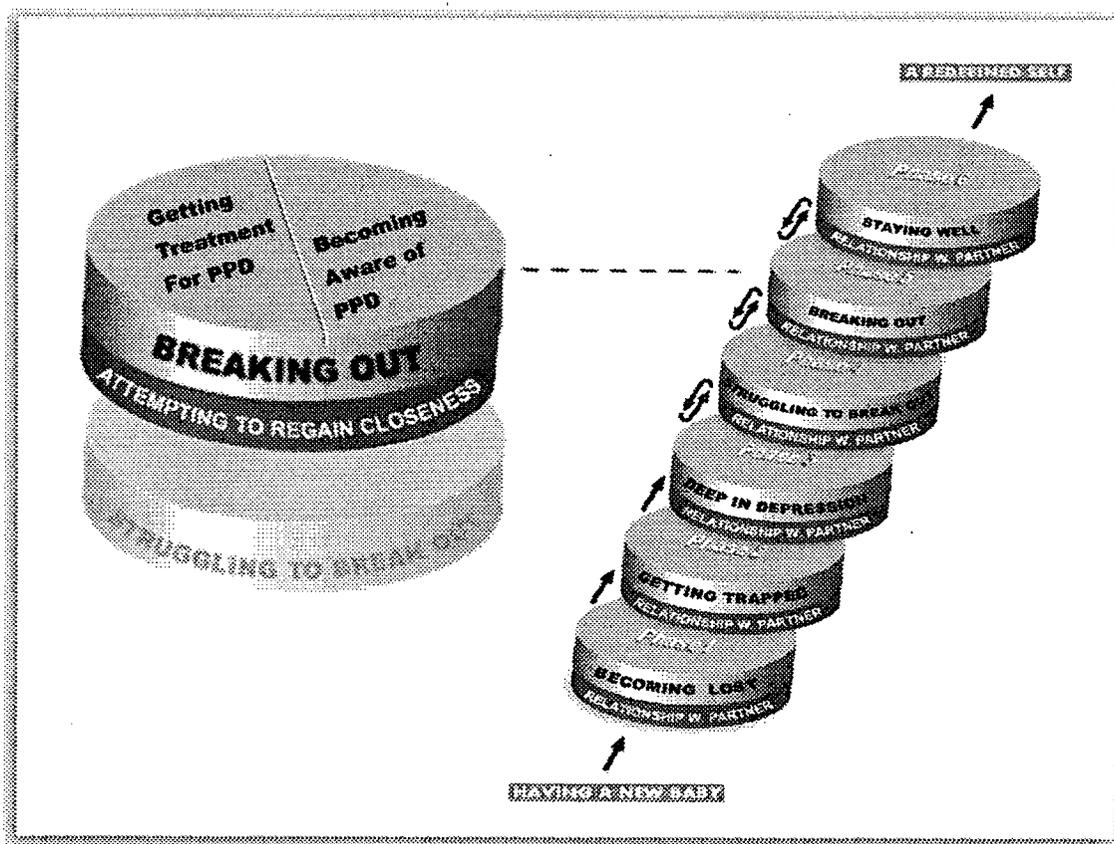


Figure 6. Breaking Out. Phase no 5 in the six-phase model of "The Experience of Postpartum Depression".

As illustrated above, the two properties of this phase were Becoming Aware of Postpartum Depression and Getting Treatment for Postpartum Depression.

Becoming Aware of Postpartum Depression

Becoming aware of Postpartum Depression was an important, even crucial step on the way to recovery for the participants in this study. As long as they were not aware of PPD they believed they were the only ones in the whole world who were feeling the way they did and that there was no hope for them. Once they became aware of PPD they realised that they were not alone, it was not their fault and that there was treatment available and therefore, there was hope.

After being dismissed by her doctor several times, Sharon made another attempt at getting help from someone else and this time, she was successful:

There was a nurse there and I told her what was going on and she told me about postpartum depression. She told me there were groups for women who are depressed after having a baby and I remember thinking it actually has a name! I'm not the only one who has it and I remember thinking 'there is a place to go with this... at least there is some action that I can take...'

There were two ways participants came to be aware of postpartum depression. The first, through being diagnosed and educated by a health-care professional and the second, by getting access to information about PPD and self-diagnosing accordingly.

Getting Diagnosed

Most of the participants were eventually diagnosed by health-care professionals. They were given the label of postpartum depression and were provided with education and treatment accordingly. After many months of suffering depression and not knowing what it was, believing that they were flawed in some way and losing hope, participants were relieved to hear the diagnosis and began to be somewhat hopeful about the future. Patsy described the process of being diagnosed by a psychiatrist who specialised in reproductive mental health. At that time she had been depressed for almost a year:

I finally went in to see that doctor and she sat down and she's asking me... she knew all the right questions to ask and... I was having all these obsessive thoughts and... she asked me 'are you having any thoughts that really scare you or some thoughts you just can't get out of your mind?' and I remember just... the flood gates opening and oh my god, 'yes these thoughts are in my head... I never wanted to act on them... but I just had these repeated thoughts and It's just been killing me' and so I remember her saying to me 'Patsy, you are severely depressed' and she wanted to start me on medication right then and there...

Karen had been dismissed several times by her own doctor. When she went to visit her sister who lives in the U.S. with the baby, her sister, who is a nurse, told her immediately that she suspected that Karen had postpartum depression. She asked a doctor she knew to see Karen immediately:

My sister knows a lot of doctors and she knew this reproductive psychiatrist... and this woman, the doctor, was just superb... she said 'my dear, you have postpartum depression and there's help...' she was like my guardian angel... she put me on Prozac and she gave me tons of stuff to read... I was so relieved... I was sobbing in her office and she just said 'I know, I know it's been hard but there's hope now...'

Much like in Karen and Patsy's cases Mary's doctor had dismissed her twice before a community nurse finally diagnosed her postpartum depression:

After the second time I went to see my doctor I didn't want to see her anymore and I was really depressed but then I met Rachel, she's a public health nurse in our community and she looked at me and said 'are you ok?' and I told her a bit and she said 'come to my office first thing tomorrow morning' and then I poured my heart to her and she's like 'you are depressed... it's postpartum depression... you're not crazy...'

Whereas some participants were diagnosed by professionals, others diagnosed themselves after getting information pertaining to postpartum depression.

Self-Diagnosing

Participants that were looking for information as described in the previous section were sometimes successful in finding information that helped them to become aware of postpartum depression and diagnose themselves as having it. Kelly was reading a book

on child-care when she found some information that made her aware of the possibility of postpartum depression:

I was reading this book and I noticed there was a chapter on maternal problems after the birth... and I read through and most of it was about pain and breast engorgement and stuff but they also said something to the effect that sometimes mothers are not happy all the time and they are tired and in pain and sometimes even depressed and I went 'that's me' so I thought 'that's interesting and I have to show it to my doctor...'

Alicia was not particularly looking for information when she happened to see a newspaper article that caught her attention:

I saw an article in the paper... it was depression awareness week or something. Anyhow, there was a symptom checklist and they said that if you check 5 you may have depression and should see a doctor-well, I ticked 12! But I knew my doctor couldn't help me so I joined a support group...

When participants became aware of postpartum depression and suspected they were having it they either went back to their doctors or started looking for other ways to get help. The road to recovery was now open.

Getting Treatment for PPD

Once they became aware that they were suffering from postpartum depression participants started to actively look for specific help. If it had been a physician who diagnosed the women they usually offered them medication, mostly anti-depressants such as Prozac. Those who diagnosed themselves or were diagnosed by counsellors often ended up getting some type of counselling. Some participants got both medication and counselling, like Celeste who refused medication at first:

I tried to go on without medication 'cause I really didn't want to take anything... I saw a counsellor but it wasn't enough. I was still fairly depressed so finally I gave in and went back to my doctor... and then I started taking medication.

Similarly Karen, who was offered medication at the time of her diagnosis, refused to take it in the beginning. She explained why:

I wanted to be one of those people who work their way through it; I didn't want to go on medication because like my partner, I didn't believe in medication...

Like Celeste and Karen, some participants were reluctant to take anti-depressants, and declined them at least initially. Others were relieved to know that there was something that might help them and embraced medication when it was offered to them.

Going on Medication

Some participants who initially declined medication later decided to take it usually because they were not getting any better. Others who were not reluctant to take medication often started taking it immediately upon being diagnosed. Most women who went on medication experienced a major turning point in the way they were feeling shortly after they started taking it. They described feeling the depression was finally lifting. They started feeling differently about themselves, their families and their future.

Karen described how she felt once she finally started taking medication:

I think that within the second week of taking it I was starting to feel better. By the third or fourth week I seemed significantly better, feeling more myself... and really the Prozac was like a miracle cure for me... it was like going from deeply depressed to feeling totally fine and actually better than fine. Not just my old self but even jollier than my old self so it seemed...

Sharon who like Karen initially refused to take medication ended up going back to the doctor for a prescription. She found the medication to be helpful in elevating her mood even sooner than she and the doctor expected:

Eventually I got my prescription and within two weeks of taking the medication I started to feel somewhat... the burden lifting off my shoulders and I couldn't

believe it... she told me it would take probably a good six weeks before I really noticed something but I went back to her saying I'm feeling a little bit better...

Most of the women who went on medication found it very helpful. Some, however, suffered from side effects and either went off the medication or had to take an additional medication to relieve their side effect symptoms, like Dianne, who was having sleep problems once she started taking medication:

With the Prozac I had lots and lots of dreams and so... I wasn't getting a good night sleep so I went back to my doctor and she also put me on Trednizone. So then, once I was on that combination it was just like, 'holy smokes, I'm actually sleeping at night...'

Participants noticed how their family members were relieved once they observed that the medication was helping them feel better. Helen remembered how she noticed her partner's relief when he realised her situation was improving:

I remember my partner who was so relieved when the medication started to kick in because he could see signs of me coming back, particularly eating stuff, you know up until then I hadn't been eating meals for maybe months and all of a sudden he could see I was sitting down and eating something and he was so relieved. I could just see a general relief right throughout the family that they felt 'oh, she's back'. I know for many people it's not the answer but for me it was a total miracle.

Most of the participants who took medication experienced some relief of symptoms after a few weeks. But as Patsy described, it was not always a smooth road but rather one with many ups and downs:

I remember too feeling very disappointed because it was still such an up and down thing you know... you'd have maybe two really good days and then four bad days and that was so frustrating to me because... I was feeling better but then I'd have four really bad days and that would just bum me right out again. It was like oh, God, I can't do this anymore you know, but as the weeks went on I was feeling better and better...

While most women who went on medication found it helpful and were eventually pleased with the results, others refused to go on medication or could not tolerate it. These women chose to get counselling instead of medication, and there were those who felt they needed counselling in addition to the medication.

Getting Counselling

Whether on medication or not, many of the participants sought counselling of one sort or another. Most of them got individual counselling and some joined a support group. There were some that went to see a marriage therapist together with their partners either in addition or instead of individual therapy. Finally, there were those who got more than one type of counselling. Sharon was one of those women. She attended a support group but found it only somewhat helpful. She later sought individual therapy for an issue from her childhood that surfaced after many years:

I think the group helped me... but I don't think it was enough at the same time. I mean there was a lot of stuff that went on... I went to the group for a year and even when I left I wasn't better. I had to do some other kind of therapy... the whole postpartum thing was bringing up so many other issues that eventually I went off to do other work that had to do with my sexual abuse history.

Unlike Sharon, Alicia found a support group that was very helpful to her. Alicia was one of the women who were on medication and got counselling at the same time:

Going to the group was tough but it took the isolation away because I was so isolated feeling lonely and like there's nobody in the world... I'm alone... so finding the group was a tremendous help, like a light bulb, enormous support. Light at the end of the tunnel...

Cynthia was one of the women who did not go on medication but who was able to find a psychologist who helped her to come out of the depression and make some changes in her life:

I refused to take medication because I felt it would be like taking drugs... you numb the pain without really dealing with the issues... so I started seeing a psychologist and she was wonderful... she helped me a lot. I understood many things about my depression and that there was a reason why I became depressed and I explored some deep issues with her and... I saw her for about a year or so and it was a wonderful process even though it was sometimes very painful... I remember bawling my eyes out in her office many, many times.

Laura went on medication for a year. When she got somewhat better she realised that some of the problems she was having in her marriage have not gone away and were still affecting her mood. She suggested to her partner that they seek marital therapy and he agreed:

There was a lot of anger in our relationship and mutual resentment... I felt he was not there for me and he felt he'd stretched himself to the fullest... we had to repair the damage to our relationship... there was a lot of damage... and the marriage therapy helped with that.

The women in this study engaged in counselling as an augmentation to medication or without being on medication at all. Whether it was individual, group or marital therapy, or a combination of the above, participants often found counselling to be helpful in alleviating some of their depression and exploring other issues.

The Relationship with the Partner: Attempting to Regain Closeness

All of the participants in this study talked about the damage to the couple relationship during the time of their depression. While in the fifth phase of their experience of PPD, when they were breaking out from depression with the help of therapy and self-care they also made attempts to improve their relationships with their partners. They felt a need to bridge the chasm that had been formed between them and their partners, a need to regain some of the emotional closeness that used to be a part of

the relationships to some degree or another. Barb described how she felt about her relationship with her partner while she was breaking out of her depression:

I was feeling better but our relationship really bothered me... we had absolutely nothing to say to each other... like strangers who happen to parent the same children... it was very sad... we weren't even fighting – we just didn't communicate and kinda lived side by side...

Dianne's partner was ready to end the relationship after a whole year of her being depressed. She recalled the emotional distance in their relationship at that time:

He was just at his wit's end... he was basically ready to leave me and the kids and go back to Arizona... it seemed like there was nothing left... the love, the passion it was all gone... we were both empty... we had nothing to give to each other... counselling was kinda the last resort... we were gonna give it a last chance...

As Dianne implied, some of the women and their partners sought professional help in an attempt to repair the relationship and regain some of the emotional closeness that they used to have. For some of them, couple therapy was a last resort before separation. Others did not contemplate a separation but were very unhappy in their relationships and realised that they needed help in that area. Lila described her experience of couple therapy:

We were basically ready to separate... things were really bad... and a friend of mine recommended a therapist she knew and we went to see her. We were very apprehensive... both of us... but actually it was very good because we could finally begin to understand what the other one had been through... it was very worthwhile...

Like Lila, some of the participants who sought conjoint therapy experienced an improvement in their relationship with their partners and gradually regained some emotional closeness with them, as Nelly described:

It was good 'cause we started to feel better about one another and we started to laugh again like we used to... we were both really sad and sorry about this awful

time that we had together... but it was like a new beginning... we could look at each other and actually feel something...

For some of the couples, conjoint sessions were the place where the partner became aware of postpartum depression, its symptoms and that it was a treatable condition rather than a character flaw, as Ruth recalled:

Dan sat there with his mouth open... he was totally choked... he finally realised that I wasn't a wacko after all... I had postpartum depression... he started to take this whole thing much more seriously... when we left he hugged me for the first time after many, many months.

While some of the participants, who went for therapy had a positive experience, others had a negative and/or unhelpful experience. Mary did not have a good experience attending conjoint counselling sessions with her husband. She described her feelings toward her husband at that time as well as her therapy experience:

I wanted him to stay away 'cause every time he touched me all he wanted was just to have sex... and I didn't want it so... I didn't even want a friendly hug... I felt alienated - not close at all! We went and saw a therapist and it was the worst thing in my life 'cause my husband would just attack and attack and attack me and, the therapist would just sit there and say nothing...

As these excerpts illustrate, whereas some participants were getting effective professional help that assisted them and their partners in improving their relationships, others were disappointed and found conjoint counselling unhelpful. The latter rarely experienced any improvement or greater closeness in their relationship with their partners.

In this phase there was a noticeable difference between the group of couples whose pre-birth relationships had been defined as “very strong and close” and the group whose relationships had been defined as “good but not great”. The differences were in the willingness of both partners to engage in conjoint therapy and the extent to which emotional closeness was beginning to be regained. Specifically, most partners in the first

group willingly participated in conjoint sessions while in the second group, both the women and their partners were reluctant or did not seek conjoint therapy. The degree of emotional closeness in the couples seemed to be related to the degree of pre-birth closeness, whether or not the couple engaged in conjoint therapy and the women's experiences of conjoint therapy when it occurred.

Summary of Phase 5: Breaking Out

Becoming aware of postpartum depression was a crucial part in breaking out of the depression. Whether the women had been diagnosed by a health care provider or self-diagnosed, the awareness that what they had been experiencing was a known and treatable phenomenon brought them enormous relief. Becoming aware of postpartum depression did not take the depression away instantaneously but it alleviated some of the anxiety that was rooted in not knowing what was going on and thinking they were going insane. Participants felt more in charge of their lives and were often able to make decisions about treatment. Some chose to take medication even if initially they were reluctant to do so. Others needed no persuasion and were glad there was medication available that could help them. Some participants chose to get counselling in addition to taking medication while others chose counselling alone and did not take any medication. The common thread among all participants in this regard was that eventually they all found counselling to be helpful to them. The difference between those that did and did not take medication was that those who took medication often experienced a much faster alleviation of symptoms than did the ones who did not take medication or had to stop taking it.

At the same time participants were becoming aware of and getting treatment for PPD, they realised there was a need for them to work on the relationships with their partners. In the women's minds, the nature of the couple's pre-birth relationship was an important factor in whether or not they could improve their relationships and regain emotional closeness with their partners. The women who defined their relationships with their partners as "very strong and close" were more hopeful about the prospects of improving the relationships than women who defined their relationships as having been "good but not great". Women from the first group were also more interested in couple therapy than the others.

Most of the women from the first group embarked on a process of conjoint therapy with their partners while others received individual therapy and brought their partners in for one or two educational sessions. Women from the second group mostly engaged in individual therapy even though a few of them did try conjoint therapy. The effect of therapy on couple relationships varied and often depended on whether or not the women found the conjoint sessions helpful. Those who did often experienced an improvement in the couple relationship and reported greater emotional closeness with their partners. Those who did not find conjoint therapy helpful rarely experienced an improvement in their relationship with their partners. These participants often remained emotionally distanced from their partners.

In general the time of recovery varied from participant to participant but they were all well on their way to recovery once they became aware and got treatment for postpartum depression. In this sample, women who experienced a positive change in the relationship with their partners reported a shorter process toward recovery and more

satisfaction from life at the time of the interview. All of them were making an effort to maintain their good mental health and stay well.

The following propositions emerged from this phase:

- 1) Women who take anti-depressants experience faster relief of symptoms than women who get counselling alone.
- 2) A woman who gets conjoint therapy with her partner rather than getting individual therapy alone has a greater chance of regaining emotional closeness with her partner.
- 3) The more a woman experiences emotional closeness with her partner the lower is her chance of relapsing into depression.
- 4) The more a woman perceives her pre-birth relationship with her partner as close and strong the better are the chances to perceive that emotional closeness has been regained following her recovery.

Phase no. 6: Staying Well

Participants had reached this last phase of the model following breaking out of their depression. In this phase, which was ongoing at the time of their interview for this study, participants had been engaging in different behaviors aimed at achieving and maintaining their emotional wellness. This phase is closely related to the previous one and flows directly from it. The relationship between the two phases is cyclical rather than linear, which means that participants were going back and forth between the two phases until they finally remained in the last one.

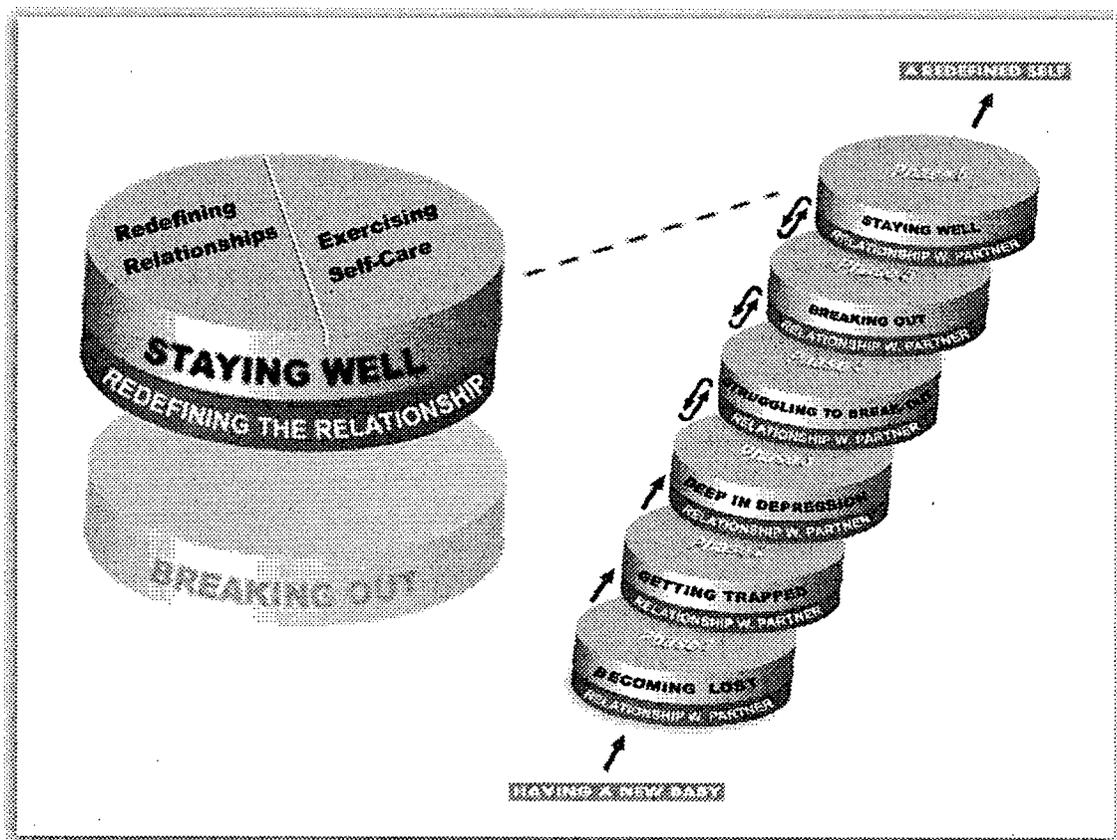


Figure 7. Staying Well. Phase no. 6 in the model of "The Experience of Postpartum Depression."

Figure 7 illustrated the relationship between this phase and the other phases of the model, as well as the internal relationship between the different properties of this phase. As the figure illustrates participants were oscillating between the current phase and the one before. I.e., they were attempting to make changes in their lives in order to stay well while they were receiving treatment for PPD, and they were still in treatment when they had already made some of the desired changes. Three major properties characterise this phase: 1) Exercising Self-Care and, 2) Redefining Relationships. In this phase participants were taking responsibility over their own well-being. They were engaging in activities and behaviors that they believed would help them to achieve their goal of staying well. In many cases they had come to realise their need to take charge of their lives and to take care of themselves, through the process of counselling. As Barb remembered:

I was seeing this counsellor and I was really angry at my partner at that time and she said 'you know', she said, 'a person's well – being is their own responsibility' ... and 'you have to take breaks and you need to take care of yourself 'cause nobody is gonna do it for you' ... and so I realised it was me who had to do something about it and so now I'm very protective of my own time...

As Barb's words indicate the women not only realised the need for them to take charge but also often started doing it. This was in complete contradiction to their demeanour in phases 1 and 2, i.e., in the beginning of the process of becoming depressed when they were absolutely not in control of their lives.

Self-Caring

Caring for their children and being responsible for the majority of household chores participants were left with little time for themselves. When they have reached this phase, however, they were making conscious efforts to make time for themselves and

take care of their own needs. As Ruth pointed out, there needed to be a shift in the way they were thinking in order for them to do that:

You have to start thinking differently, right? 'cause all the time you're focused on the baby and your partner and everyone's needs and you forget to think about yourself and what you need... sometimes it was ... as if I didn't exist but only as a maid... well, you've gotta stop thinking this way and actually think of yourself as an equal part of this equation – you matter too kinda thing... but I'll tell you, it's very hard to shift gears like that.

The women realised that in order to be and stay well they needed to take care of their physical and emotional needs as well as their personal freedom.

Fulfilling Physical Needs

Unlike the state of affairs during the first three phases of the experience of PPD when their physical needs were ignored and denied, at this phase the women made sure that these needs were being addressed and fulfilled. Sharon remembered how at first she felt guilty about leaving her children with a baby-sitter and how she overcame that feeling:

I think one of the biggest things for me was getting some breaks... and eventually the woman across the street, I worked it out with her and she took the kids out for two days of the week. So I knew Tuesday and Thursday I'm gonna have to myself... and getting those breaks, you might feel so guilty but eventually you don't notice the guilt because you start to see the benefits... I was allowing myself that time...

For Cynthia, taking a break was fulfilling both an emotional and a physical need:

I remember going from one thing to the other and never having a break... and I was just exhausted from doing things all the time and my brain just shut off. And so when I eventually got the nanny it was such a big help to me because I could rest, I could take naps if I had a really bad night and my brain kinda cleared out from having a little space to myself.

Nelly was so severely depressed that her doctor suggested a ten-day residential care program. She remembers it being a turning point for her, realising that she needed to self-care in order to maintain her good health:

I was a pressure cooker and this program was a safe place for the lid to come off. I got ten days away from my kids. They fed us with great meals and being taken care of... it was a safe place. Eventually I realised that that's what I needed to do so I don't totally collapse and now I'm being very careful not to go back to that place where I totally collapsed and couldn't function.

As Ruth pointed out earlier, participants found it hard to change their ways from ignoring their own needs to suddenly putting themselves high on their priority list. In order to be able to do so the women felt they needed to become more assertive, as Laura explained:

We'd be sitting at the dinner table and Jessica would be on my lap and I wouldn't be able to eat really... and so finally I said I had to put an end to it... I put her in her chair and she cried but she got used to it. And I said to Michael 'we have to take turns with the kids'. So we started dividing the weekends between the two of us because before I was taking care of them all the time and I said 'I need my rest too, I need to be able to sleep in at least one day a week...'

Another reason why the women started taking care of themselves in this phase was that they understood they needed to do so in order to be able to take care of their families, as Dianne explained:

For me the whole thing was a big eye-opener 'cause what do they tell you all the time? You have to sleep well, eat a balanced diet and exercise... to be healthy I mean and I... of course as a Mom I didn't do any of that and then I fell apart. So really, it's either I take care of myself or I won't be able to take care of anybody... so if you're feeling guilty – do it anyhow! (laughs).

The women in this study also found that it was very easy to slide back to not taking care of themselves but that when they did they were also starting to relapse into feeling down and angry, as Helen clarified:

It's really easy to go back to your old ways... being a Mom and working and all that. But for me if I didn't take care of myself ... I wasn't flying into those rages or being as down as I used to, but the anger would still be there. And still today

that's my alarm... if I start to get really snappy with the kids I know I need a break...

At the same time participants had been taking care of their physical needs they came to understand they should not be neglecting their emotional needs either.

Fulfilling Emotional Needs

Following the birth, participants were getting neither their physical nor their emotional needs met. When they had been going through the process of recovery they learned to express their needs and make sure their needs such as support, nurturing and personal space were being met. Jody learned to express her need for affection and nurturing from her partner with the help of a therapist:

I wasn't used to saying what I needed and wanted and my partner... well, he's your guy type of guy. He used to be such a Mr. Fix it and I hated him... And I learned to say to him 'please, I need for you to listen to me now! don't try... don't feel like you have to fix things... I just need you to listen... I just need you to put your arms around me and show me you're here for me'...

As a way of getting some of her needs met Lila went back to doing Yoga and getting massages as she used to before the birth of her first child:

I've always done Yoga ever since I was a teenager and I found it very rewarding... it keeps me centred. And massages... it's the ultimate nurturing experience for me... I feel so pampered and taken care of... so I went back to my old massage therapist and I absolutely never miss an appointment anymore-I go every week, very religiously (laughs).

For many of the participants going out with friends was emotionally recharging and some of them started doing it on a regular basis, like Kelly who said:

My partner and I decided that each one of us would get an evening to themselves... to go out or do whatever we want. So I started going out with friends again... I have a few friends... two of them in particular that I go out with and when I'm back I feel full of energy. And even if I came back late at night the next day I would be calm and full of energy...

While each participant found what she needed in order to fulfil her emotional needs they all said it was a challenge to keep doing it with their busy schedule and endless commitments. However, remembering the “price they had paid” as a few of them phrased it, they were making genuine efforts to keep it up. Another challenge that the women talked about had to do with their personal freedom.

Redefining Personal Freedom

Once they became mothers participants sensed that their own freedom had been taken away from them as was discussed in the first part of this model. When they were in the process of coming out of depression participants came to believe that regaining their freedom was of utmost importance to their well-being. However, they realised that expecting to go back to exactly the kind of freedom they had had before they had children would be unrealistic. Thus they described a process of redefining rather than regaining their personal freedom as one of the tasks of become and staying well, as Ruth explained:

I used to feel very suffocated at home with the baby and I just wanted my old lifestyle back where I was used to doing things as I pleased all the time but you realise that it's not gonna be like that ever again 'cause you're committed now... so I just said ok. I can't have exactly what I had before but I can have something, you know, to make me feel I actually have a say in how my life would be...

The freedom to make decisions and follow them through was one of the most important things for participants as Cynthia pointed out:

I needed to be able to actually make decisions...from little things like what I want to do this evening to whether or not I'm gonna go back to work and am I gonna work full time or part time and whether or not I even want to go back to my old job 'cause I didn't like it... and eventually I quit and I said 'hey, I'm allowed to make decisions...I'm a free person after all' (laughs).

One of the challenges that the women experienced was the need to find a balance between their responsibilities at home and their need for some degree of freedom, as

Alicia explained:

When you have 3 small children then freedom becomes an oxymoron (laughs)... parenting rules your life...I know I felt extremely tied... home - bound 'cause I was always taking care of the kids and never doing anything for myself... but I learned to have little bits of freedom. I structure my free time and so now on Tuesdays and Fridays I have a baby sitter and I'm the one who decides what I'm doing... choice is very important... to be able to make choices is really important to me.

Redefining personal freedom was one of the ways participants had been taking care of themselves. To have some freedom, even if not the kind of freedom they had been used to before becoming parents, was very important to all of them. Thus they found ways to have some freedom, a different type of freedom than they had had in the past but still, a very important part of feeling like a human being again and not merely a parent. Another thing that participants engaged in doing was redefining their relationships.

Redefining Relationships

During the time of their depression participants' important relationships were negatively affected. Participants became alienated and emotionally detached from family and friends during that time and that was something they were not happy with. As a way of becoming and staying well, participants started cultivating and redefining relationships that were important to them, particularly the relationships with their partners, their babies/children and with close friends and other members of their extended families.

Helen explained why she believed she had to work on her relationships:

I was so disconnected from everyone for such a long time... people didn't know what to expect anymore and I've lost some good relationships I had before the depression... so I had to do something about it... I feel like in many cases I have to

initiate this... they're not just gonna say oh, you're back - now everything's gonna be the way it used to be...

Redefining the Mother – Child Relationship

One of the issues that all women were upset about while they were depressed and also while looking back on that time in their lives was the relationship with their babies/children. As discussed under the third phase of this model they felt ashamed for not being able to function as “good mothers” and to provide their children with more than their elementary needs. Upon their recovery the women in this study made a conscious effort at redefining their relationship with their children. They tried to do that by spending more time with their children, engaging in enriching activities for the children and bestowing their affection upon them, as Patsy described:

Looking back on that time I know I wasn't connected to them at all... I was barely surviving and I know they've suffered a lot. I've been trying really hard to find the balance between being with them and having some space... but when I'm home I'm trying to minimise house chores... I do it while they're asleep... I try to play with them a lot and I actually enjoy it... I read to them and I just give them a lot of love...

Alicia has also been trying to make up the lost time with her children. She felt she had been robbed of her experience of motherhood. Now that she has come to terms with the past she is trying to make the most of the present:

I feel quite cheated – there's a part of me that would like to have another baby. I feel I've lost track... I missed out, I didn't get to enjoy having a baby... I'm just trying to make up a lot of lost time here and I'm doing everything I can to give my kids and my self what we've missed before...

Like Alicia and Patsy, Karen has also been trying to make up for lost time, as she believed she was not bonded to the baby at all when she was depressed:

I managed to keep the baby clean and take care of his needs but nothing more... when I look back on it I know I wasn't at all bonding with him and it makes me very sad... so after that when I was better I wanted to make it up to him... we had to work on our relationship and he was very good about it because he's been very loving to me and I feel... I'm so glad I got better because now we have a lot of time to make up for it...

Cynthia felt she had to invest a lot in her relationship with her older child because while she did take care of the baby she felt she had neglected him:

With the baby, I had no choice 'cause he was screaming his head off and I was always holding him in my arms... my son suffered the most because I didn't pay a lot of attention to him and he loved my husband more... he wouldn't let me put him to bed for the longest time which was killing me... I've had to do a lot to gain his trust and his love again... he's a bright child and he sensed that something was wrong...

The women in this study believed they had to make a strong effort to rebuild and redefine their relationship with their children. Those who had older children often believed that they were the ones who suffered the most. Those who had only one child when they were depressed sensed that they had not bonded with them at the time. All of the women were trying to make up for lost time, to nurture their children and to gain their love and trust. Another important issue for these women was their relationship with friends and other members of the family.

Redefining Relationships with Family and Friends

Whereas redefining the relationships with the children took the first place in terms of importance to the women, some of them also mentioned having been working on other relationships. The women believed that their relationships with family members and some friends were adversely affected during the time of their depression. Now that they were getting better they were often trying to re-establish and redefine those relationships.

Patsy described how the relationship with her mother had been affected because she had avoided involving her mother in her life during the time of depression:

My mother was devastated when she found out... she was like 'why couldn't you talk to me?' and 'I'm so sorry I haven't been there for you' and I know it was me... how would anybody know if you don't tell them? But [once she knew] she was very supportive... and now we're much closer... I realised she wouldn't judge me and she wants to help... I'm much more open with her now...

Some relationships were altered as a result of people's behavior during the time of participants' depression. For example, following her suicide attempt Alicia was hospitalised for a few weeks. At that time there was one friend who kept visiting her regularly. This was someone she had not been very close with before her depression. On the other hand the person she considered her best friend did not come. She described how her relationships with these two friends had changed:

A friend of mine who's had schizophrenia came to visit me but my best friend didn't... I learned some things when I was at the hospital... I am now much closer with that friend than with the one who used to be my best friend... I realise she's someone I can trust... I can be who I am... I don't have patience anymore for people I have to pretend with...

Some of the relationships that had been important to the participants were negatively affected by the depression. Jody realised she had to work hard in order to re-establish some of her old relationships with dear friends due to her withdrawal and rejection of people at the time of the depression:

There was a time when I didn't want to see anybody... people would phone and I would just either not pick up or say 'I'm sorry I can't see you' or 'I'm really busy with the baby' but the truth was that I just didn't want to be with people... I was in my shell all the time... now that I'm better I wanna see people but not everyone is ready to go back to what we had before and I'm also not interested in being friends with everyone... I have to invest in the friends that I care about...

Like Jody most of the participants experienced changes in their relationships with friends and family members. Some relationships were either lost or altered - others were strengthened. The process of redefining these relationships involved making choices and conscious attempts on the part of the participants. The result of this process depended both on the participants' effort and their friends' co-operation.

To summarise, participants sensed that their relationships with significant others had been adversely affected during the time of their depression. Of utmost importance were their relationships with their children, but relationships with other family members and friends were also important to them. Participants realised that old relationships might never go back to the way they had been before. They made some choices with regards to the relationships they wanted to cultivate. They also made special efforts to make up for lost time and redefine these relationships, trying to make them better. Most of the participants were successful in improving their relationships with their children and with some friends and family members.

The Relationship with the Partner: Redefining the Relationship

All of the participants, without exception, stated that their relationships with their partners had suffered to some extent. Redefining the couple relationship was both a contributor to and a result of the recovery process. Participants and their partners had to make a conscious effort to make things better between them. Usually it was the women's initiative to try and repair the relationship as Dianne explained:

I noticed we'd become really alienated and we used to be such good friends... I said to myself we had to do something about it and at one point I said to my partner 'you seem to be angry' and he said 'I am... I don't want to be but I have a lot of anger...' and so we went to see a marital therapist, which was very helpful...

Like Dianne's partner Alicia's partner was also very angry and used to take it out on the children. Alicia suggested counselling when she felt that the marriage was being threatened. Her partner agreed and she was very supportive of him as she felt that her depression had been a major contributor to her partner's anger:

My partner was constantly yelling, snarling, bitching and complaining. The kids were reacting to it. I became angry with him... we came pretty close to splitting up... I still loved him, didn't want to lose him. He joined an anger management group... things got better... I really understood his anger... we also started talking... I said 'this relationship is important – we need to do something about it'.

Following the counselling process and the effort they had both made Alicia and her partner became much happier as she said: "we love each other very much, we're much closer and talk about things... we're much more open with each other now". Vis-à-vis the process of repairing the relationship, the couple relationship were being redefined. Participants realised that the relationship may not and should not be exactly the way they used to be before they had children. They were working toward regaining emotional closeness in the relationship and they negotiated the new terms of the relationship as well, as Karen explained:

There was a lot of hurt on both sides... we realised things could not go back to what they were... but maybe it was better because we worked on things and were... almost like a new couple 'cause we understood each other better and we knew what we should and shouldn't do to have a good relationship.

Sharon explained how following getting individual counselling she realised how non-empathic she had been toward her partner. Like some other women and their partners, Sharon and Peter have been trying to repair and redefine their damaged relationship. Here, Sharon described how she had come to understand her partner's experience and the way they have been working on their relationship:

I was so angry with him for not being there for me not able to see that he was also not getting his needs met. I was angry with him for being angry with me... but he was a Dad that did get up at night for the kids... he was actively looking after them and he was also sleep deprived... But we have been working on that and have been trying to make it a better place for ourselves... keep communication open so we don't fall back into our old patterns...

Not all of the couples in this study succeeded in repairing their relationship and although none had divorced or separated, a few of them were still unhappy in their relationships. One of these couples was Mary and her partner Raymond. Their relationship deteriorated following the birth of their first son and when Mary found out she was pregnant again she became angry and resentful toward her partner as she described:

[After the first birth] I didn't like my partner... I thought to myself 'what am I doing with this man?' and when I found out I was pregnant with Jason I hated him even more... I was furious at him for doing this to me... for forcing himself on me... I mean he didn't do it on purpose but I still really resented him... it's affected our relationship a lot. I don't feel close to him and I don't think I will... so we're basically roommates and parents, that's all... that's all there's to it now.

Mary and her partner did make an attempt at healing their relationship but unlike most couples, who participated in this study, they have not been successful in doing so. They described an alienated and cold relationship. Like other couples, Mary and Raymond redefined their relationship at this phase, however, according to Mary, they redefined the relationship as much worse than it used to be in the past. They have come to regard themselves not as a couple but rather as roommates who happen to have children together. A few other women in this sample had a similar experience to that of Mary's. These were women who defined their pre-birth relationships with their partners as "good but not great" and whose experience of conjoint therapy was negative. However, most of the women who defined their pre-birth relationships as "very strong and close" stated that

their attempts at improving the relationship with their partners were successful even when their experience of conjoint therapy was not extremely positive.

Summary of Phase 6: Staying Well

In the sixth and last phase of this model participants were taking initiative to maintain and improve their wellness. They broke out of depression and improved their mental health through becoming aware and getting treatment for postpartum depression as described in phase no. five. Their task at this phase was to stay well vis-à-vis making themselves a priority and structuring life-style changes accordingly. As well, they had to invest in their relationships and redefine them so as to fit their post depression state of self. One of the great challenges the women had, if not the greatest one was the need to balance their responsibilities for their families and their own physical and emotional needs. Being the serious challenge that it was, participants struggled quite a bit to cope with it. However, they realised that it would be easy for them to slip back into depression if they did not place themselves at a high priority. Another big challenge in this phase was the need to redefine the relationship with the partner. The women realised that these relationships had to be repaired and renegotiated. Things had changed in the relationships as a result of the experience of PPD and as the result of the new understanding that participants gained following the experience, sometimes with the help of a therapist. Most of the participants in this study were successful in achieving a positive redefinition of the relationship. However, a few of them ended up giving up on the relationships with their partners as close and rewarding and settled for alienated relationships, which they defined as roommate-like rather than couple-like.

The propositions that emerged from this phase are as follows:

- 1) The more a woman takes care of her own physical and emotional needs the greater is her sense of well being.
- 2) The less a woman takes care of her own physical and emotional needs the greater her chances are to relapse into depression.
- 3) The higher the emotional closeness between a woman and her partner the higher she perceived their chances of staying together and the more life-satisfaction she will perceive.

In the next section I will present and discuss two additional themes that emerged from the data. One has to do with the relationship with the partner and the other with the process of redefinition of self. These themes were not a part of any specific phase but rather, they were interwoven throughout the participants' stories.

Theme no. 1: The Relationship with the Partner

The relationship with the partner came up very frequently in the women's stories. All of them perceived change in the relationship vis-à-vis their experience of postpartum depression. The importance of the relationship with the partner became evident as the women kept referring to it without being prompted to do so. Thus, the relationship with the partner was woven into the participants' stories from beginning to end and is defined as a recurrent theme in this model.

Two groups of couples emerged from the data. The first consisted of couples whose relationships were defined by the women as having been very close at the time of birth or before it occurred. An example of that type of relationship was Sharon and her husband Peter. Sharon said:

Peter and I were a couple that came from a very solid base and we had ourselves on a pedestal and so did a lot of other people. We were a very strong and close couple and very sure of what were doing...

The second group consisted of couples whose relationships have been defined by the women as "ok" or "good but not great" as Mary described:

We were ok before the birth. [We] were each doing our own thing and then on weekends we would go out and have a good time together... it was nice to spend time together... it wasn't great but it was ok.

As was outlined throughout this paper the relationships between the participants and their partners changed in each phase of the experience. Figure 8 illustrates the changing relationships with the partner parallel to the phases of the experience of postpartum depression.

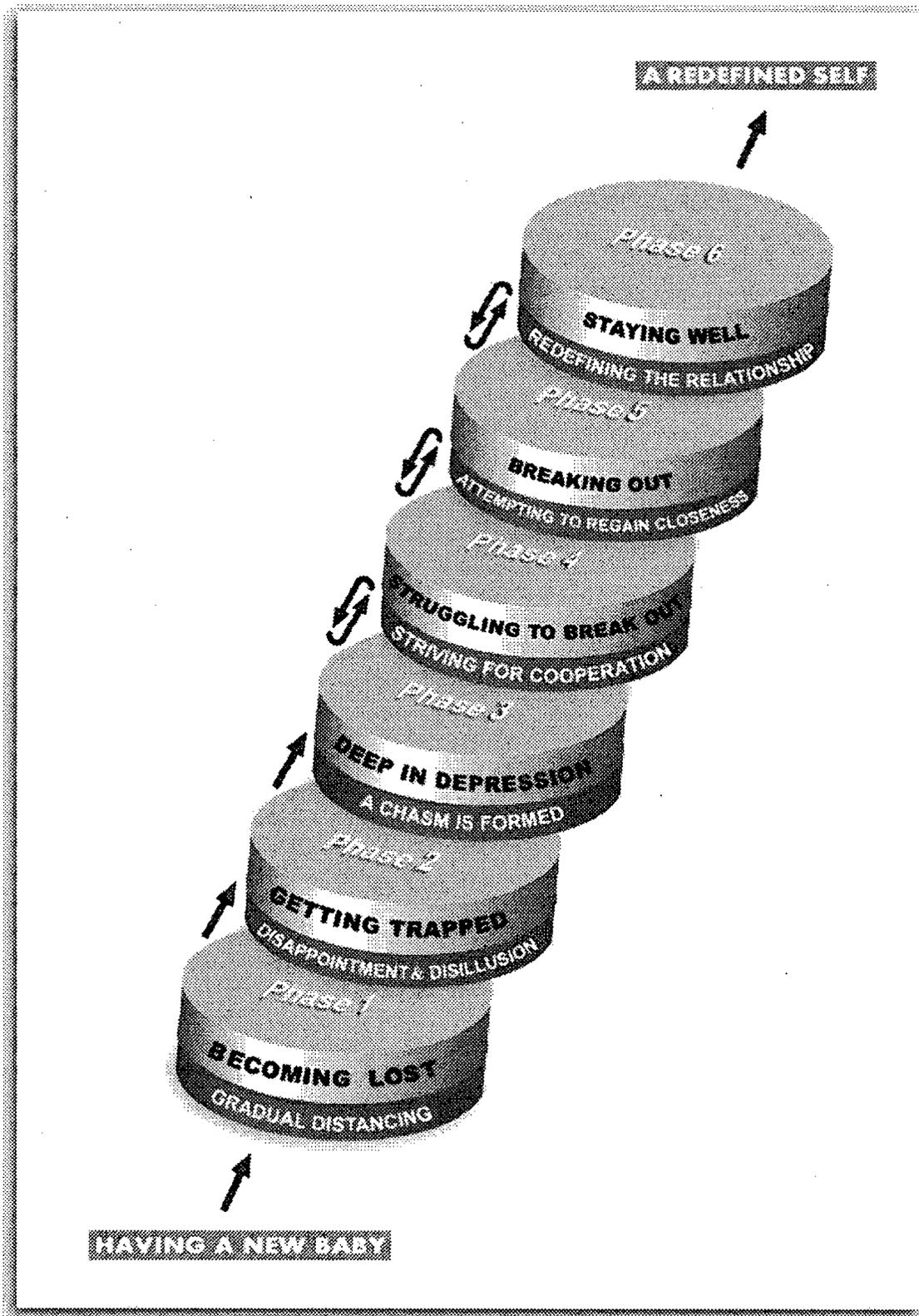


Figure 8. The Changing Relationship with the Partner. A recurrent theme in the model of "The Experience of Postpartum Depression".

The relationship with her partner was an integral part of the experiences of each woman in each one of the phases.

As the titles of the relationship with the partner in each phase imply, there were some differences in the relationships among the two groups of couples. According to the participants, the two groups of couples underwent a similar process in the first three phases of the experience but had different experiences in the latter phases. The initial and similar process that the two groups underwent was as follows: whatever the degree of pre-birth closeness in the relationship had been there developed a pronounced distance and loss of closeness between the two partners in the first few phases. This common process is identified in the first 3 phases as represented by the titles Gradual Distancing, Disappointment and Disillusion and A Chasm is Formed. The difference between the two groups was evident in the latter 3 phases when the women were coming out of depression. These phases were entitled as follows: Striving for Co-operation, Attempting to Regain Closeness and Redefining the Relationship. As the titles suggest, the women were working toward improving the relationship with their partners. The degree to which they were successful in doing so varied greatly between the two groups. Women who perceived their pre-birth relationships with their partners as having been very good and very strong experienced gradual decrease in distance and an increase in emotional closeness in the latter phases. However, women whose relationships with their partners were not very close and strong often did not succeed in regaining closeness and ended up feeling alienated from their partners. Another variable in this process was the nature of the couple's experience of conjoint therapy session. Having a good experience often helped the couple in gaining mutual understanding and regaining emotional closeness.

Having a negative or a neutral experience did not help the couple and they often remained alienated from one another. Alicia, who defined her pre-birth relationship with her partner as “very strong” described how her husband’s attitude changed following a visit to the psychiatrist and how it affected their relationship:

He began to understand really what I was going through... that this was serious stuff and that I couldn't help it... he became more understanding and more supportive... we could look each other in the eye again and feel something for one another...

Women who defined their pre-birth relationships as “ok” or “good but not great” often referred to their relationships as having been “permanently damaged” (Mary) or “damaged beyond repair” (Helen). A couple of participants from this group were contemplating separation at the time of the interviews for this study. One of them was Mary who said:

I've been thinking of taking the kids and going back east where my family is... we'll see what happens... he's my husband and the kids' father but I don't care for him very much anymore... I have to take care of myself... I can't count on him to take care of me...

To summarise, the relationship with the partner constituted an important part of the women’s experiences of postpartum depression. All of the participants perceived an initial process of emotional distancing from their partners and believed that the relationships had been severely damaged. In the later phases, however, most of the participants perceived an improvement and greater closeness in the relationship, but a few participants perceived a permanent damage and great alienation in the relationships. The two most common variables that varied between the two groups were (a) the degree to which the relationship had been defined as close and strong versus alienated and weak, and (b) the couple experience of conjoint therapy as perceived by the women. The

propositions that emerged from the theme of the relationship with the partner are as follows:

- 1) The stronger and closer a couple's relationship before birth is the greater their chance to regain closeness and strength in their relationship following postpartum depression.
- 2) The more positive a couple's experience of conjoint therapy is the greater their chance to regain closeness and strength in their relationship following postpartum depression.
- 3) The more a woman perceives her partner to be involved and interested in the couple relationship the greater the chance is that emotional closeness will be regained.

Theme no. 2: A Redefined Self

Looking back on the experience of postpartum depression the participants in this study described it as a process, which resulted in a redefinition of their selves. Redefining self was an ongoing process throughout the experience. However, participants testified that the change in self as a whole was felt at the end more than during the process. The meaning of redefining self for the participants was that they experienced a change in their selves that was pronounced enough to feel differently about their selves and who they were as human beings. The impact of the experience and the meaning they gave to it created the change in self-perception. The change was neither good nor bad as a whole but rather was perceived as having had both positive and negative components. For example, Celeste described the difference she felt in herself:

I don't think I'm the person I used to be... this experienced has changed me a lot... I look at things differently... I look at myself different... I'm more aware of things now... I'm happier and I'm more compassionate toward other mothers... I also have this experience... this awful time in my life that has left me... with a big scar...

The process of redefining self consisted of three properties: self-awareness, Self-Acceptance and Self-Growth.

Self-Awareness

Many women in this study reported having become a lot more self-aware following the experience of postpartum depression. Becoming aware meant that the women have grown to examine themselves and who they were and to know themselves better than they did before. Being aware of their strengths and weaknesses was an important part of it, as Cynthia recalled:

I've come to realise, for example that I am not terribly patient with little kids... I like older kids better... I get along with them better when they can express themselves more clearly and not just scream their heads off (laughs). But I also learned that I could be really effective in listening to other people... that's something I'm really good at and I've just found that out about myself.

Helen also described a process whereby she had learned new things about herself:

In that group I understood that I'd been a perfectionist all my life... big time! Something that I'd never thought about before 'cause I've always thought this is how things should be... I also learned that I was really good with my hands and I'm very patient when it comes to stencilling for example...

As a part of the process of becoming self-aware participants had to be able to admit to themselves that certain traits were indeed parts of them. This was not always easy, especially when they regarded these characteristics as undesirable. For example Lila became aware of her impatience with others and of her tendency to dismiss other people's concerns:

It was a great experience for me 'cause I learned a lot about myself... good and bad things... like in the group... I was so miserable that I sometimes couldn't see how everyone else was also in pain... I could say something like 'oh, that's not too bad' to someone and I wasn't very patient at all... I wasn't aware of that before and I think you should know these things about yourself.

Many participants became aware not only of personality traits but also of patterns of behavior that they often engaged in. Ruth became aware of the way her endless giving was taking its toll on the way she was feeling:

I was giving and giving and giving endlessly not ever stopping to think of myself but what I didn't realise was that I was becoming more and more resentful and that eventually I would take it out on my family... I was being a martyr and it wasn't a good thing...

Barb became aware of her tendency to internalise her anger instead of expressing it. She realised the contribution that this tendency had to her depression:

Expressing anger... I had a problem with that... a big problem... it's just the way I grew up in my family-you didn't express anger... you're expected to... deal with it!

But the anger was piling up more and more in me and I understand now it may have been a part of my depression... that I didn't let it out...

Thus, going through the experience of postpartum depression and therapy participants became more aware of themselves and who they were. They got to know their strengths and weaknesses as well as some behavioural patterns that they used to engage in, some of which they perceived as having contributed to their depression. Upon increasing their self-awareness participants felt they had to exercise some self-acceptance in order to be happier about who they were.

Self-Acceptance

Participants came to understand that self - acceptance, i.e., the ability to look at yourself and come to terms with who you are, was a crucial component of being well and happier or content in your life. Accepting oneself was not always an easy task for the women, especially when traits that they had identified in themselves were unappealing to them. Most of all they had a difficulty accepting traits or needs that were considered to be incompatible with the way they perceived their maternal role. Ruth described how hard it was for her to accept the fact that she needed her own space and could not spend all of her time with her children:

I had to accept the fact that maybe I was not the motherly type who enjoys being with her kids twenty-four-seven... I just can't do it... after a while... it just drives me crazy and so I'm taking it up on them... but it's really hard to admit that that's the way you are... I wanted to be different... to feel different about it...

Similarly, Barb had to accept that she did not particularly enjoy the activities with her children that she believed that as a good mother she was supposed to perform and enjoy:

I wanted to do all that... colouring, cutting and pasting, making cookies and all that but I just found that I wasn't enjoying it very much... I wanted to do it for my kids and for the most part I did it but oh, it was boring to me... I realise that I'm

just not like that... I just don't enjoy this type of activities... now I believe that I'm still a good mom... even so...

Thus, participants considered their ability to accept themselves a very important and positive outcome of their experience of postpartum depression. However, while there were some traits and needs that participants realised they had to accept in themselves and were able to do so, some participants, who would not accept certain aspects of themselves decided to work toward self-change and growth.

Self-Growth

There were mainly two types of changes that participants perceived as positive and growth enhancing. The first consisted of changes that the women felt were a result of going through the experience of postpartum depression. These were changes in understanding and attitudes toward a variety of issues that were related to themselves, others, and their beliefs about motherhood in particular and life in general. The second type of change was initiated by the women themselves as a result of their new understanding. These were changes that the women chose to make, usually in the course of therapy that they were now benefiting from.

Most participants described the first type of change as positive albeit involuntary. For example Helen talked about a general sense of having undergone a profound change following her experience of PPD:

The horrible experience that it was, it had some positive sides... I feel that I have grown... I've matured a lot... I understand things better... what's important and what's not as important to me... above all who I am...

Karen described how she had become more compassionate and less judgmental toward other people following her experience of postpartum depression:

I've always been a person who's very... not smug, but I think a little bit harsh on people in terms of people who didn't cope well, or if I had a cousin or somebody who wasn't coping I would be harsh with them saying 'what's wrong with them they should pull themselves together and get on with it' and here was I in the same scenario and that was a big wake up call for me because I don't think now I judge people in the same way as I used to... I feel that I'm a much better person than I was prior to my postpartum because I think I have more compassion in me now and I'm less judgmental of people because I know it can happen to anybody- it happened to me.

Similarly, Alicia believed she could understand other women who were having difficulties coping better than before. Following her own experience of severe depression, obsessive thoughts of harming her children and her suicide attempt she could understand women who turned to desperate acts while being severely depressed:

You see in the newspaper ... some horrible tragic story... and you think to yourself 'oh, my God, how could this woman possibly do that?' – Well, now I know how that woman could possibly do that. It certainly has given me a different perspective. Life is not just black and white.

As is evident from Karen and Alicia's recounts most women perceived the changes they experienced in themselves as having contributed to their growth and maturity and as having helped them become better people. Whereas some of the changes resulted from having gone through the experience of PPD itself other changes were initiated by the women and often required hard work. Lila described the woman she had become following her conscious efforts to change:

I worked very hard on myself... I had to change many things or else I wouldn't be able to hang in there for long... I've definitely grown a lot... I've become much more assertive, sometimes to the degree my husband doesn't like (laughs)... I changed a lot of things about myself... even my ways of thinking... I'm not catastrophising so much anymore... and I'm definitely less of a perfectionist... I don't have to have everything perfect all the time...

Cynthia also worked hard to change things about herself. Her goal was to become more confident and self-reliant:

I learned that it was my own responsibility to help myself. I changed my expectations about other people... I learned to ask for help when I need it but also to be able to help myself... definitely my confidence in myself has improved a lot... I know I can manage... I'm not that little desperate weepy girl anymore...

Most of the women in this study felt that they have changed, mostly for the better, following the experience of PPD. Their self-growth was the result of a combination between changes that came about simply through their experience, and changes that they have made conscious efforts to achieve.

To summarise, at the time this study was conducted the women who participated in it all shared a sense of a change in their selves. In other words, they have gone through a process whereby their selves were redefined. Having a redefined self was a result of a long process that started shortly after the birth and evolved through the six phases of the experience of postpartum depression. The women were often profoundly affected by their experience. Most of them perceived PPD as a profoundly negative experience that had some positive outcomes. One of the positive outcomes was their ability to become more aware and more accepting of themselves and others. They perceived the process they had gone through as a major contributor to their self-growth and their redefined self.

The propositions that emerged from this theme were as follows:

- 1) The more a woman is able to accept herself the more she is likely to perceive her redefined self as positive.
- 2) The more a woman perceives herself as having experienced self-growth the more she is likely to perceive her redefined self as positive.

Summary

The substantive theory that is presented in this chapter describes the social-psychological aspects of the process of redefining self through the experience of postpartum depression. The six-phase model describes the process of becoming depressed, being depressed and coming out of postpartum depression. Redefining the self is presented as an ongoing process throughout the phases. This process culminated following breaking out of the depression and experiencing a period of perceived wellness. The overwhelming majority of participants perceived their redefined self as more positive than their pre-depression self. They were appreciative of the contribution of the experience of PPD to their personal growth albeit defining it as extremely difficult and trying.

Most of the participants described the onset of postpartum depression as sudden and surprising. However, when asked to look back on the time between the birth and the onset of depression all of them described a period of pronounced denial of their needs and a profound sense of isolation, which may have led them to become depressed. Most of the participants also felt that their depression was overwhelmingly powerful as opposed to their own powerlessness and helplessness. Aside from feeling down and hopeless most participants were unable to function well, were having anxiety and panic attacks and were experiencing obsessive thoughts of harming their children. The women blamed themselves for their lack of ability to cope and for the anxiety and obsessive thoughts they were having. As a result they grew to hate and disown themselves, which, in return, exacerbated their depression even more. The longer their depression lasted the

more depressed the women became and the more often they experienced suicidal ideation. Following initially giving in to the depression the women attempted to come out of the depression either on their own, with the help of a professional or by a combination of the above. Most of the participants who turned to health-care professional were initially dismissed and misdiagnosed, which devastated them and threw them back into the depth of depression for a varying lengths of time. Finally, however, they became aware that they were having postpartum depression and received treatment for it, following which they came out of the depression. The experience of depression and the therapy they received brought the women to assume more responsibility for their mental health. In order to stay well the women made changes in their lives that made it possible for their own needs to be met.

The relationship with the partner was a recurrent theme in the participants' stories. All of the participants perceived having endured emotional alienation from their partners in the initial three phases of the experience. The women divided into two groups during the last three phases of the experience. Women who defined their pre-birth relationship with their partners as having been very close and very strong managed to regain emotional closeness with their partners. Women who defined their pre-birth relationships with their partners as having been good but not very strong did not perceive the emotional closeness with their partners to have been improved following their coming out of the depression. Whether or not the women engaged in conjoint therapy and the nature of the experience of therapy also played a role in the degree to which they perceived emotional closeness with their partners. Specifically, women who had very strong relationship who engaged in conjoint therapy and had a positive experience

reported emotional closeness with their partners the most. Women who had good but not very strong pre-birth relationships with their partners and who either did not pursue conjoint therapy or had a negative experience in therapy were the most likely to report current emotional alienation from their partners.

CHAPTER V

DISCUSSION

Glaser (1999) recently pointed out that the final step in formulating a grounded theory should be the establishment of its usefulness and relevance. Three parameters that warrant discussion in this process are (a) the effectiveness of using the grounded theory method in developing a theory that extends beyond extant theories in the area of the experience of postpartum depression, (b) the contribution of the substantive theory itself to the existing knowledge in this area, and (c) the implications of the theory that has been generated in this study to both future research and practice. Accordingly in this chapter I first discuss the effectiveness of using the grounded theory method in this particular study. I then go on to discuss the contribution of this theory to the area of postpartum depression in light of extant literature. I follow with a discussion of the implications for future research, and finally the implications for practice.

Effectiveness of Grounded Theory Method

In this study I explored the social-psychological aspects of women's experiences of postpartum depression, and developed a substantive theoretical model that elucidates this experience from the perspective of the participating women. The experiences of these women, as described by them in this study, were undertaken as the starting point of the theory development (Glaser & Strauss, 1967). The broad questions that guided this investigation were, "what is women's experience of postpartum depression", and "what are the social-psychological components of this experience?" The theoretical model that I developed as a result of this study is an initial answer to these questions.

This study demonstrates the usefulness of the grounded theory method for the development of a substantive theory of women's experiences of postpartum depression. Utilizing this method, the theory addresses some of the limitation of extant literature in this area by (a) conducting a study in a natural environment rather than in an artificial setting like a laboratory, (b) constructing a theory that is rooted in participants' experiences (i.e., women who actually experienced postpartum depression) rather in a researcher's preconceived ideas on the issue under investigation, (c) describing the experience in context rather than as an isolated phenomenon, and (d) elucidating the experience of postpartum depression as a process and identifying the relationships among its different properties and conditions. The results illuminate women's experience of postpartum depression as a social-psychological process, which the women both affected and were affected by. While the theoretical model that is the result of this study describes common aspects of the experience of postpartum depression it is broad enough to allow for individual differences. Thus, the model illustrates the common elements of the process while pointing to variations in different women's experience. Using the grounded theory method in this study allowed me to stay as close as possible to the data, and thus to the participants' experiences. At the same time it enabled me to conceptualise a theoretical model that explains that which constitutes these experiences. In other words, it has allowed me to develop a theory that is grounded in the data (Glaser & Strauss, 1967; Strauss & Corbin, 1998). As I discuss in the next section, using the grounded theory method allowed me to unravel the process of redefining self through the experience of postpartum depression. It also enabled me to discover some components of the experience that have not been discussed before. Finally, the theoretical framework that

emerged from this study generated a number of hypotheses that may guide future research and thus may contribute to the formation of a formal theory of the experience of postpartum depression (Glaser & Strauss, 1967).

Contribution to the Extant Literature

A review of the most recently published literature on postpartum depression reveals that despite concentrated researchers' efforts to identify the causes of postpartum depression results are still inconclusive (Hendrick & Altshuler, 1999; O'Hara, 1997). For example, in a recent extensive review of the literature on possible biological determinants of PPD (Hendrick & Altshuler, 1999) the authors conclude that results in this area are questionable and that it is therefore of great importance to continue the search for etiological factors in order "to allow for better development of preventive and treatment strategies" (p. 78). Similarly, studies that explore social and demographic variables in relation to PPD are inconclusive and sometimes contradictory (Beck, 1996; Mauthner, 1999).

One of the problems with the studies in this area is that the overwhelming majority of studies use quantitative research methods, looking for relationships between one or two variables and postpartum depression. In 1996, Brockington observed that a study that looked at all the possible contributing factors and their relative association with PPD had not yet been published. Recently, I reviewed the published studies on PPD from 1996 until February 2001 and was also unable to find such a study. In designing the current study I believed that a good way to start researching the complex phenomenon of PPD was to conduct a qualitative study, specifically, a grounded theory study that would explore the women's experience of PPD and would generate a substantive theory

including some hypotheses with regards to contributing variables to PPD. Another reason for conducting a qualitative study was that the women's experiences and the meanings that the women make of these experiences have been ignored and therefore have been absent from published research until recent years (Lewis & Nicolson, 1998; Mauthner, 1999; Stoppard, 1998). The needs to include contextual aspects of women's lives and to listen to the women's experiences have guided these efforts (e.g. Beck, 1992 & 1993; Mauthner, 1999; Stoppard & McMullen, 1999). Still, in a combined search (using PSYinfo and MedLine) of studies that have been published in the past 5 years in the area of PPD I found that less than 4% of the studies had used qualitative research methods. The overwhelming majority of studies use quantitative methods aiming to establish correlation between different variables (e.g., Da Costa et al., 2000; Meyers, 1999). A few of the studies describe treatment options for postpartum depression (e.g., Apfel & Handel, 1999; Creedy & Shochet, 1996; Whiffin & Johnson, 1998).

Finally, the theoretical model that was developed suggests that postpartum depression is a very complex phenomenon and that many factors, rather than one or two, play a role in it, which may be the reason why previous research in this area has been inconclusive. In the following paragraphs I discuss some of the hypotheses that emerged from each of one of the phases of the model, in light of extant literature.

Phase 1: Becoming Lost

The first phase in the theoretical model was the one preceding the onset of depression and may be conceptualized as having set the stage and/or led the way for the onset of depression. The two properties that characterized this phase were Denial of Self and Isolation. The types of denial of self were 1) Denial of physical needs such as

sleeping, having a break, eating and maintaining body hygiene. 2) Denial of emotional needs such as being emotionally supported and nurtured, and 3) Denial of personal freedom. The theoretical framework of this study suggests that it is the combination of these variables that may be a part of the cause of PPD, rather than one or two variables alone. Few studies have examined the physical conditions that women experience prior to the onset of PPD. While some studies found moderate correlation between fatigue and PPD (e.g., Caltabiano & Caltabiano, 1996; Milligan et al., 1996; Small et al., 1994), few studies looked at the broader and yet more detailed picture of deprivation and denial of a woman's physical needs, emotional needs and need for personal freedom all at once. As well, some studies, mostly those which are conducted from a feminist perspective, point out to the correlation between isolation and PPD (Crouch & Manderson, 1993; Kaplan, 1992; Lesser, et al., 1999; Small et al., 1994; Welburn, 1980). There are few studies that explore the combined contribution of the various types of denial of self and the experience of isolation as they were identified in this study. This finding sheds light on the complexity of conditions that exist for some women following childbirth and may lead to the onset of postpartum depression.

Phase 2: Getting Trapped

In the second phase of the experience of PPD as identified in this study the women felt that they were suddenly trapped by depression. I.e., they experienced the onset of depression as sudden and unexpected. This was true for all of the participants. Few quantitative studies have explored this phenomenon. On the other hand in her grounded theory study Cheryl Beck (1993) describe the sudden onset of depression. She named the first phase of her model 'Encountering Terror' and explained:

In this initial stage women were hit suddenly and unexpectedly by the postpartum depression... when postpartum depression hit, mothers felt trapped in a dark tunnel with no foreseeable escape (p. 44)

Thus, the findings of this study support Beck's (1993) findings in the area of the onset of postpartum depression. Beck's (1993) first stage in her model parallels the second phase in the theoretical model of this study, but not completely. The condition of being helpless was evident in the participants of this study's stories and is therefore a part of the theoretical framework. Some feminist theorists have discussed women's depression in the context of helplessness. For example, Romito (1990) who studied 44 middle-class French women found that 57% of her sample became depressed and argued that women are socially conditioned to be helpless. She draws on Seligman's (1975) theory of learned helplessness postulating that mothers are overwhelmed by the gap between their expectations and their actual experience of motherhood, especially the medicalization of birth, the unequal division of household chores, isolation and inequality in the labour market. Romito (1990) postulates that the greater the gap between a woman's pre-birth expectations and her experience of motherhood, the greater is her sense of helplessness and her chance of getting depressed. This, however, does not answer for the fact that not only first-time mothers get severe PPD but also women who are having a baby for the second, third or fourth time, etc. The women in this study did not often discuss the gap between their expectations and the reality of motherhood, maybe because most of them were not first-time mothers. Their helplessness was a reaction to the combination of denial of self, i.e., extreme fatigue, having no break, feeling emotionally unsupported and feeling isolated as well as facing the overwhelming

power of depression. Thus, this study confirms the sense of helplessness as a part of the experience of PPD but it does not provide support for feminist accounts of helplessness due to socio-political factors.

Phase 3: Deep in Depression

The third phase in this model was named Deep in Depression. It occurred when the women experienced ongoing relentless depression that they thought would never go away. This phase's properties were: Giving in to Depression, Going Insane and Disowning Self. This phase, like the others, is described as a part of the whole process of the experience of PPD. In this phase participants became overwhelmed by the depression, they functioned poorly and they felt hopeless. Because quantitative studies do not explore participants' experiences there are no studies that explore the experience of being overwhelmed as a part of being depressed. However, the data from this study indicated that for the participating women being overwhelmed was an important part of being depressed and that it played a significant role in the women's experiences of PPD.

Poor functioning is another condition that emerged from the data. The women perceived themselves to have functioned very poorly at the time of depression, which bothered them a lot. Specifically, having difficulties taking care of their children caused them a lot of grief and guilt, which exacerbated their depression. This is another aspect of PPD that few studies, be they qualitative or quantitative, have addressed.

Another property of the third phase was 'Going Insane'. This refers to the women's sense that they were losing their sanity or, in their words 'going crazy'. The conditions that characterized this property were: having obsessive thoughts of harming the baby and anxiety and panic attacks. In psychiatric literature, obsessive thinking and

anxiety attacks are considered co-morbid disorders rather than an integral part of depression (e.g. Ballard et al., 1993; Brockington, 1996; Kendall-Tackett, 1993; Stuart et al., 1998). However, in a recent study by Stuart et al. (1998) the authors found the incidence of postpartum anxiety (16.8%) to be similar to the incidence of depression (18.7%) at 30 weeks postpartum. The findings from this study support the idea that women who experience depression following childbirth have a high probability of also experiencing anxiety. The women in this study did not experience anxiety to be separate or different from the depression but rather as an integral part of their overall experience of depression. Jennings et al. (1999) studied 100 clinically depressed mothers with a child under 3 years old. The author compared this group with a group of 46 non-depressed mothers in relation to thoughts of harming the baby. Seven percent of non-depressed mothers and 41% of depressed mothers admitted to thoughts of harming their infants. In another study by Wisner et al. (1999) the researchers compared two groups of women, one with major depression unrelated to childbirth and the other with postpartum major depression. They found that while 60% of women in the non-postpartum group had obsessive thoughts, 95% of women with postpartum depression were having obsessive thoughts the content of which was aggression toward their newborns or infant. Beck (1993) found that the women who participated in her study experienced "relentless obsessive thinking" (p.45), mostly about being bad mothers and bad persons. My study supports the findings from other studies that obsessive thoughts, with the specific content of harming their children is a part of the experience of postpartum depressed mothers. Almost all of the participants experienced obsessive thoughts with this type of content.

These findings imply that obsessive thoughts with the specific content of harming the child may be an integral part of PPD.

Another condition that co-existed with depression for the women was having suicidal thoughts. Suicidal ideation has been long identified as a complicating factor of depression and is now an integral part of screening tools for depression (e.g., The Beck Depression Inventory). In this study, however, the women perceived a connection between experiencing anxiety and obsessive thinking and having suicidal thoughts. This finding supports Beck's (1993) finding that the postpartum depressed women in her study were "contemplating and attempting self-destruction" (p.45). Beck also points out that one of the contributors to the women's thoughts of self-destruction, or suicide was having obsessive thoughts of harming their babies. These findings from both Beck's (1993) study and from my study imply that women may be unable to reconcile the contradiction between their self-perception as mothers with having these disturbing thoughts of harming their children to the extent that they think about, contemplate and sometimes attempt suicide.

Another interesting finding of this study was that the women grew to disown themselves, through self-hate, self-blame and shame. While few studies use Self-Disowning as a variable, a few studies have explored the relationship between self-criticism (Priel & Besser, 1999) or self-acceptance (Dimitrovsky et al., 1998) and postpartum depression. For example, Priel and Besser (1999) studied 73 first-time pregnant women and tested them for self-criticism, attachment to the unborn baby and dependency. They found that self-criticism in pregnant women predicted postpartum depression and that the risk for depression was lowered if the women became strongly

attached to the unborn baby. In another study forty-nine primiparous Israeli women were tested on measures of general and maternal self-acceptance during the last trimester of pregnancy and again 6 to 8 weeks following childbirth (Dimitrovsky et al., 1998). The authors found that women who were high in general self-acceptance were less depressed and displayed less negative affect than those low in general self-acceptance. There was no difference between the high and low maternal self-acceptance groups and postpartum depression. The authors conclude that low self-acceptance was a risk factor for postpartum depression. Self-disowning, which was one of the properties of phase 3 of this model, can be conceptualized as a combination of self-rejection (the opposite of self-acceptance), self-blaming and shame about self. In this regard, this study confirms the co-existence of low self-acceptance and high self-criticism and postpartum depression. However, while the above-mentioned studies conceptualized these variables as contributing factors to PPD, this study conceptualizes them as having a reciprocal relationship with depression. This is due to the fact that the women perceived their self-disowning to have appeared with the depression and feeling like going insane and in turn, to have contributed to more depression.

Phase 4: Struggling to Break Out

In the fourth phase of the theoretical model the women were trying to break out of the depression. They started engaging in activities that they believed might help them to break out of the depression and they also looked for information and for professional help. This finding contradicts the common medical view of depressed women as passive and helpless, especially the notion that PPD women are victims of their own hormones (e.g., Dalton, 1989). The women in this study exhibited varying degrees of agency at

various phases of the experience. Although they were mostly passive when they were initially overwhelmed by depression, later on in the process they did attempt to help themselves and to get help from others. The problem was that while the women were struggling to pull themselves together in order to be able to seek help, they were often dismissed and misdiagnosed by health-care professionals once they had finally approached them. Few quantitative studies identified the process of struggling to break out, including being dismissed and misdiagnosed. However, Beck's (1993) grounded theory study also identified that women were "battling the system" as she described:

Once the decision had been made to seek professional help, women began a tortuous path to find the appropriate treatment. Disappointment, frustration, humiliation and anger were experienced by mothers in their initial call to health professionals for help (p. 46)

A recent study by Aitken and Jacobson (1997) that examined the level of awareness and knowledge of the Edinburgh Postnatal Depression Scale (EPDS) found remarkably low levels of knowledge, skill and familiarity with EPDS among general practitioners and psychiatrists in England. The findings of my study as well as Beck's (1993) suggest the possibility that some health care professionals in North America may also have a low level of knowledge in the area of PPD. What the findings of this study illuminated in addition to identifying the problem in getting appropriate help is the effect that the experience had on the mothers. As detailed in the results chapter, failing to get the appropriate help, as well as being dismissed and misdiagnosed resulted in a worsening of the women's depression. The women were often devastated, became more hopeless and contemplated suicide following an unsuccessful visit to a health-care

professional. This finding is one of the unique contributions of this study to extant literature.

Phase 5: Breaking Out

In the fifth phase of the model women were breaking out of the depression through becoming aware and getting treatment for PPD. Becoming aware of PPD was perceived by the women as a major breakthrough because up until then they were not aware that some other mothers experienced similar symptoms. Thus, the women in this study were relieved to have their symptoms labelled as postpartum depression. This label was much easier for them to take than believing that they were going insane and that they had a rare and unique case of an unredeemable character flaw. This finding contradicts the findings of some feminist authors who argue that labelling a woman as having PPD is dis-empowering and offensive. For example, Nicolson (1991/2) notes that the women she had interviewed refrained from using the label 'postpartum depression' and referred to themselves as having been "low", "down", "fed up" and "upset". She argues that they were trying to stay away from identifying themselves as having had postpartum depression because of the pathology associated with this label. Similarly, in a more recent study Nicolson (1999) found that the women explained their experiences

in terms which relate more closely to accounts of depression following an event such as hospitalization, psycho-social transitions and disruption and loss than they do to those encapsulated in the traditional clinical/medical discourse (p. 176)

This study, however, does not confirm Nicholson's finding. In my sample the women were relieved and thankful to be diagnosed and reassured that their condition, postpartum depression, was not due to a rare and unique flaw that they had; that it was a

well-documented condition and that there was treatment available for it. These women sensed that something was very wrong with them and they welcomed the label of PPD that reassured them rather than dismissed them as being “stressed out” or “merely adjusting to motherhood”. The differences in findings may be explained by the differences in the samples that were investigated. Whereas the participants in my study were women who identified themselves as having had depression following childbirth, the women in Nicolson’s (1999) study were pregnant non-depressed women some of whom may have become depressed following childbirth. Their choice of words like “low”, “down” and “upset” differ significantly from the words that the women in this study used like “overwhelmed”, “desperate”, “terrified”, “paralysed” and “hopeless”. Thus, it seems that some participants in Nicolson’s (1999) study may have had mild transient depression if any, which may be normal in the postpartum period, while the participants in this study had fully blown major depression following childbirth. Unfortunately, there is no way to verify that because neither study used standardized measures of depression.

Getting treatment was another way the women in this study were able to break out of their depression. While some of the women were reluctant to take anti-depressants others welcomed the medication with a sense of relief; finally there was something that could help them; finally their complaints were taken seriously. None of the participants complained about having been put under pressure to take medication or to receive any other treatment. Once they finally got to see a specialist that diagnosed them as having PPD, they sensed that they had a choice regarding their treatment. Although most of them were offered medication some of them declined it and received only counselling. Others

initially declined medication but later on decided to go back to their doctors and ask for it. Finally there were those who started their treatment with anti-depressants and later on decided to seek one form of counselling or another. These findings do not support the feminist view that conventional psychiatric approaches to treatment of depression are inappropriately “medicalizing” and “pathologizing” women’s distress (Caplan, 1995; Greenspan, 1993; Nicolson, 1999; Russell, 1995). The experiences of the participants in this study suggest that this is not always the case and that some women welcome mainstream treatment approaches to PPD. Interestingly enough, the women in this study did not feel “pathologized” by the mental health professionals that offered them medication, but rather by those professionals who dismissed and misdiagnosed them. Their perception was that if health-care professionals did not know what their problem was then this meant that they must have a horrible untreatable disease and that they were truly “crazy”. There is at least one study that supports this finding. Gammell and Stoppard (1999) interviewed 40 women who had been depressed and had received standard psychiatric treatment for depression, supplemented by counselling sessions. All but one agreed to take anti-depressants and the women who had used them considered the medication helpful in alleviating their symptoms. However, the authors note that the women felt that

the strategies employed in coping with their depressive symptoms were more likely to have disempowering than empowering consequences. Typically, the women had adopted strategies that re-instated them more firmly in lives already characterized by gendered disadvantages associated with having primary

responsibility for caring activities within the family and limited economic resource. (p. 126)

The authors conclude that the benefits of anti-depressant medication should not be downplayed. At the same time researchers and clinicians alike need to explore ways in which different theoretical approaches to women's depression should be reconciled and integrated, and that women should have a choice in the type of treatment they get.

The findings of my study suggest that some women find the mainstream medical treatment for postpartum depression helpful, they believe they have choices and they welcome having them. These findings support Gammell and Stoppard's (1999) argument that women need to have choices concerning their health in general and their mental health, in particular. It does not support, however, the notion that every woman who receives "medicalized" care necessarily feels "pathologized" and "disempowered". Some women do, and some women do not. Women are individuals with different needs, wishes and preferences, rather than one homogenous group. Feminist researchers and practitioners should be aware of that too.

Phase 6: Staying Well

In the last phase women were proactive in an ongoing attempt to stay well once they had recovered from postpartum depression. They did it mostly through self-care and redefining relationships. Following some self-exploration with or without a therapist, the women knew what they needed to do in order to stay well and they took initiative in doing it. In other words, women took charge of their lives and thus their agency was evident in this phase. Little research has targeted questions about women's agency in

becoming and staying well. This study adds to extant knowledge on the experience of postpartum depression and on the ways women help themselves out of it.

The Relationship with the Partner

The relationship between marital satisfaction and postpartum depression has been extensively researched. In her meta-analysis of predictors of pre and postpartum depression Beck (1996a) found that on the average the relationship between marital satisfaction and postpartum depression was in the range of a moderate effect size. In a more recent cross-cultural study Stuchbery and her colleagues (1998) studied 105 Anglo-Celtic, 113 Vietnamese and 98 Arabic women living in Australia. The women were assessed for postpartum depression and social support. The authors found that there was a great similarity among the three ethnic groups in terms of the relationship with the partner and PPD. Specifically, for the Anglo-Celtic women low postpartum mood was associated with perceived need for more emotional support from partners and from their own mothers. For Vietnamese women, low postpartum mood was associated with poor quality of the relationship with the partner and a perceived need for more practical help from him, and for Arabic women, low postnatal mood was associated with perceived need for more emotional support from partners. The findings of my study support the idea that women often perceive lack of instrumental help and emotional support from their partners before the onset and during the experience of postpartum depression.

Another significant contribution to the extant knowledge on the couple relationship and PPD was the identification of the process that the couple relationship goes through during postpartum depression. Little has been written about this area. Whereas most studies aim to establish a correlation between low marital satisfaction or

high marital distress and postpartum depression, this study began to unravel the process of change in the couple relationship, mostly in terms of emotional closeness. The findings suggest that while the degree of emotional closeness varied from couple to couple before the onset of depression, all of the couples in this study experienced a process of emotional distancing. As well, couples whose pre-depression relationships were defined by the women as strong and very close managed to regain emotional closeness to a higher extent than did those whose relationships were defined as good or fair. Having a successful experience with conjoint therapy also made a difference; women whose pre-depression relationships with their partners were strong and very close who also had a positive therapy experience were feeling the happiest and the most optimistic about the future. Women whose experiences in conjoint therapy were negative were less happy and less optimistic about the future. These findings need further study as discussed in the section on implications for research.

A Redefined Self

The participants in this study experienced their selves as having been redefined. This occurred as a result of the impact of the experience of postpartum depression as well as a result of the women's own agency. The process of redefining self had three components: self-awareness, self-acceptance and self-growth. The majority of women described their redefined self as more positive than it had been before they experienced PPD. The idea that a woman's identity changes following the transition to motherhood has been discussed elsewhere (e.g., Bergum, 1989; Michaels & Goldberg, 1988; Nicolson, 1999; Oakley, 1980). However, the concept of redefining self, mostly in a positive way, through the experience of PPD has been rarely discussed. Beck (1993)

found that at the last stage of PPD the women were regaining control over their lives. The findings of this study support and expand on Beck's findings. Not only did the women regain a sense of control over their lives but they also gained self-awareness, practiced self-acceptance and experienced self-growth. The process of redefining self that was identified in the current study is another contribution to extant knowledge in the area of PPD.

Is PPD a "Normal" Part of the Experience of Motherhood?

Finally, there has been an ongoing debate in the literature on postpartum depression regarding the question of whether postpartum depression was an abnormal, pathological phenomenon or a normal reaction to motherhood (e.g., Mauthner, 1999; Nicolson, 1999). Traditionally, quantitative research that has been conducted from a medical model perspective, has defined postpartum depression as objectively pathological, an illness that needs to be diagnosed and treated (e.g., Cox & Holden, 1994; Dalton, 1989; Nonacs, & Cohen, 1998; Steiner & William, 1999). On the other hand, feminist researchers that usually utilize qualitative research methods argue that the medical model is inappropriate because it ignores the context of women's distress and the political and social conditions within which PPD develops (e.g., Lewis & Nicholson, 1998; Nicholson, 1999). Feminist researchers argue that it is wrong to define postpartum depression as an illness or a disease. Rather, they suggest, postpartum depression should be conceptualized as a normal and even healthy reaction to women's life conditions such as their inequality and inferiority in a male dominant society, and their multiple losses following childbirth (Nicolson, 1999; Oakley, 1980). For example, Paula Nicolson (1999), who interviewed 23 women during their pregnancies and then again following

their births, found 'Loss' as the major common theme among the women. Her conclusion was that most women experience some depression following childbirth as a result of major losses in areas like their sense of autonomy and identity, their work, time and relationships. Nicolson postulates (1999) that

Overall, therefore, postpartum depression is, not pathological. Some degree of postpartum depression should be considered the rule rather than the exception. It is also potentially a healthy, grieving reaction to loss (p. 176)

The findings of the current study do not support this perspective. The women who participated in this study perceived the experience of postpartum depression to have been out of the ordinary. They felt neither 'normal' nor 'healthy'. Rather, the symptoms they endured made them feel like they were losing their sanity, and their sense of well being. They considered themselves as having been unwell at the time of the depression as opposed to becoming and staying well following breaking out of the depression. While Nicolson (1999) describes the participants in her study as having gone through periods of being 'down', crying and being upset about their losses the women in this study described a long period of severe and relentless depression, anxiety and obsessive thoughts that often drove them to consider suicide as their only way out. In other words, the participants in this study portrayed a much more severe picture than did the participants in Nicolson's study. Again, I believe that the differences lie in the different groups of women that were interviewed for these two studies. Nicolson (1999) recruited women who were not identified as depressed but rather were a group of pregnant women who "were willing to make a commitment of around 10 hours of time over the research period" (p. 164). The inclusion criterion for my study, however, was that participants

defined themselves as having been depressed following childbirth. All of the women who participated in my study identified themselves as having had postpartum depression. My conclusion is that when one studies the general population of recently delivered women one may find that most women experience some sadness, weepiness and frustration due to their multiple losses and difficulties. However, only some of these women will experience severe ongoing depression, often accompanied by impaired functioning, anxiety and obsessive thoughts of harming their children. These women have postpartum depression, which cannot be considered a normal reaction to motherhood not only because the minority rather the majority of recently delivered women experience it in its fully blown form, but mostly because it does not seem normal to the women themselves.

To summarize, in light of the scarcity of qualitative studies in the area of postpartum depression, this study contributes significantly to the accumulation of knowledge in the area vis-à-vis a utilization of a research method that has been inappropriately underused in the research of women (Charmaz, 1996; Mauthner, 1999; Rafuls & Moon, 1996). Specifically, this study's contribution to extant literature is in elucidating postpartum depressed women's experiences and in presenting a theoretical framework that is grounded in the data and that may help us to better understand this experience. This study describes a process in its context rather than focus on isolated variables. We are thus able to start seeing the whole picture of PPD in a clearer way.

Another contribution of this study is the identification of new variables and clarification of others that are related to the experience of postpartum depression. It helps to establish not only the commonalities among women with PPD but also the differences. As well, the theoretical framework of this study illuminates the process of change in the

couple relationship, which is an integral part of women's experience of postpartum depression. These, and the identification of a process of redefining self through the experience of PPD, are unique contributions to extant literature. Finally, the findings of this study have been discussed in light of the ongoing debate on whether PPD is a normal or a pathological reaction to motherhood. The findings of this study suggest that PPD is not a normal reaction to motherhood because PPD mothers see it as abnormal and wish to get treatment for it.

Implications for Research

To say that the experience of postpartum depression has been under-researched would be a gross understatement. Studies in the area of postpartum depression that were published during the past few decades rarely focused on women's experiences. Rather, they often explored biological, psychological and social variables and their relationship to this phenomenon as discussed earlier from the standpoint of the researcher, as discussed earlier. It is only in recent years that some studies have been published, which explored the experience of PPD from the standpoint of the knower, i.e. the women who had PPD. The substantive theory, which is the result of this study contributed to bridging the gap of knowledge in this area. However, further research is needed in order to refine the theory, explore some of the building blocks of the theory further and compensate for the theory's limitations and delimitations. The two issues that warrant discussion under this section are: 1) future research in recognition of the limitations of this study and, 2) future research in recognition of the findings of this study.

Future Research In Recognition of Limitations

The findings of any grounded theory study, including this one, cannot be generalized. Much more research is needed in order to accumulate further knowledge in this important area. Also, this study was conducted in British Columbia, Canada. Although some of the participants lived in rural areas of the province most of them lived in the province's urban areas. It would be worthwhile to conduct studies that specifically explore women's experiences of PPD in rural communities all over Canada and the U.S. in general and in BC in particular. As well, despite the fact that some of the participants

belonged to minority groups they were underrepresented in this sample in comparison with their representation in BC's population as far as I am able to attest. Furthermore, some minority groups were not represented at all in this study. Because mothering is affected by social-cultural variables, it would be important to design a study that would compare the experience of PPD in different minority groups (Stuchbery, 1998). For example, it has been observed that in some cultures childcare is performed by members of the extended family and sometimes is shared by the community as a whole (e.g., Chung & Yue, 1999; Weisner & Gallimore, 1977). Little is known about the epidemiology of postpartum depression in minority groups who have immigrated to North America. For example, to what extent, if at all, do minority groups keep their cultural childcare practices in their new environment? If they do not keep their traditional childrearing practices what is the effect, if any, on maternal depression? If they do keep their traditional child rearing practices does serve as a buffer against postpartum depression? Other questions that warrant more investigation are, do women who belong to minority groups utilize the health care system if they experience PPD? If they do, what is their experience of it? If not, what are the barriers that keep them from doing so?

Another group that was not represented in this study are single mothers. In the past two decades there have been an increasing number of women who either choose to have a baby outside of a relationship or end up having to do so due to their life circumstances (Belliveau, 1999; Entwisle & Alexander, 2000 Golombok, 1999;). These women were not included in this study because one of the inclusion criteria was that the woman would be in a relationship. I included this criterion due to the fact that one of the purposes of the study was to examine the couple relationship during the experience of

PPD. It would therefore be appropriate to design a study that would compare the experience of PPD in single and married or co-habiting mothers. Since one of the findings of this study suggests that emotional closeness with a partner plays a positive role in a woman's recovery, it would be interesting to see what happens when there is no such relationship. Also, some of the participants in this study said they had expectations to be instrumentally and emotionally supported by their partners. Some interesting research questions may be: who, if anyone, do single mothers expect to receive support from? Who do they actually receive support from? What is the percentage of single mothers who become depressed following childbirth and is it different from mothers who are in a relationship?

Another group that was underrepresented in this study were lesbian mothers. In the past decade an increasing number of lesbian women have been having babies who they raise with their female partners (Gartell et al., 1999; Golombok, 1999; Hequembourg & Farrell, 1999). It would be interesting to explore the similarities and differences between heterosexual and homosexual mothers in terms of the experience of PPD. What is the percentage of homosexual mothers who become depressed following childbirth? What are the similarities and differences between heterosexual and homosexual mothers in terms of the couple relationship? Do lesbian mothers also experience emotional distancing from their partners during PPD? Do they have similar expectations from their partners, as do heterosexual mothers? What about gender roles? Does the biological mother in a lesbian relationship, like the mothers in this study, assume the role of the caretaker and the nurturer while her partner assumes the role of the provider or is it different for them and if so, in what ways?

Another limitation of this study was that, none of the women who volunteered to participate in this study belonged to a particularly low socio-economic group. Therefore we are missing an important piece of information about the experience of PPD among less privileged and less educated women. It would be important to explore the experience of this group of women and to compare it with the experience of other groups. Future research needs to explore ways that would help us access these women and encourage them to participate in a study like this one, while keeping in mind ethical guidelines for recruiting participants.

Another interesting issue in this study was the lack of support from extended families. Extended families were almost completely absent from the participants' stories, either because they lived far away, or because the participants did not wish to involve them and ask for their help. It would be important to try and find women who had some family support during postpartum depression and explore whether or not and how family support may influence the course and the nature of the experience of postpartum depression.

Finally, all of the participants in this study mentioned their relationships with their partners as a very important component of the experience of postpartum depression. In many cases they complained about lack of support, empathy and instrumental help. As well, they all felt emotionally alienated from their partners during the time of depression. It would be interesting to explore the partners' perspective on the experience and the process that they went through. Also, we may be able to better understand the relational processes by comparing the women's and the men's points of view.

Future Research In Recognition of Findings

The findings of this study consist of a substantive theory of the experience of postpartum depression. As such, the concepts of this theory are grounded in the data and are suggested rather than proven (Glaser, 1978). Aside from generating a theory, one of the goals of grounded theory is to generate hypotheses that would lead to the development of further theory. The propositions that were presented and discussed in the findings chapter may lead to the development of hypotheses that could be tested in future research. In the next few paragraphs I discuss the possible contribution of these propositions to the design of future research.

One of the findings of this study was that the women who experienced PPD perceived a denial of their physical and emotional needs prior to the onset of depression. A hypothesis for future research may be that there will be a positive relationship between a woman's perception of denial of her physical and emotional needs and her chances of experiencing postpartum depression. One may design a study whereby postpartum women are being measured on scales that indicate their perceived denial of needs (one may have to design such a scale). The women could then be divided into two or three groups according to their score range. Later, the occurrence of PPD will be examined to determine whether or not there was a correlation between a woman's degree of perceived denial of needs and her chances of experiencing postpartum depression. Another proposition in the findings was that the women in this study perceived themselves to be isolated both physically and emotionally. An interesting study may be designed whereby isolation is examined as a mediator in a woman's chances of becoming depressed. For example, if we expand the study that was suggested earlier, we can examine whether

women who scored similarly on scales of perceived denial of needs were more likely to become depressed if in addition they perceived to be isolated.

Another hypothesis that emerged from this theory was that the longer the depression lasts the more severe it becomes and the higher the woman's suicide risk is. A longitudinal study may be designed where postpartum women are randomly divided into two groups. For the first year after the birth one group could receive education and periodic assessment of postpartum depression. Women who are found to have PPD will receive treatment. The other group will not be followed during the year and will receive no education other than that offered regularly to the local community. Both groups will be assessed a year after the birth for occurrence of postpartum depression and severity of symptoms experienced including suicidal ideation. The hypothesis for this study may be that women who are provided education and early treatment for PPD will have less severe symptoms than women who are not identified early and are not provided with education and early treatment for PPD.

Another finding of this study was that many of the women who had PPD experienced obsessive thoughts of harming their children and anxiety. It was unclear from this study whether obsessive thoughts and anxiety were a part of the depression or a co-morbid phenomenon, which may be clarified in further studies. Another hypothesis that emerged from this study is that women who experience obsessive thoughts and anxiety may be more severely depressed than women who do not experience these symptoms. A mediating factor was self-disowning whereby the women, having these symptoms start deprecating, hating and turning their backs on themselves and thus become more depressed.

Yet another important finding was that women, who were dismissed and/or misdiagnosed by the health care professionals they turned to for help, became devastated and more depressed than they were before. On the other hand, those who were diagnosed as having PPD the first time they reached out for help started the process of coming out of the depression almost immediately. One may assume that women who live in rural areas may possibly have less access to specialized health care than women who live in big urban centres. Thus, one may presume that women living in urban centres will have a better chance of getting diagnosed and treated earlier. This study was unable to detect such a difference. In fact the three participants who had been most severely depressed in this sample lived in the city near major hospitals but still were misdiagnosed by the health-care professional they sought help from. Future research should explore the level of awareness of PPD as well as the familiarity with assessment tools and appropriate treatment among practitioners both in urban and in rural areas of BC in particular, and North America in general.

An additional interesting finding was that some women, once having been diagnosed chose their own treatment: some chose to receive counselling alone, others chose medication alone and yet others received both. It was unclear from the findings of this study which, if any treatment modality was superior to the others. More studies are needed that would explore the efficacy of different treatment modalities and modality combinations for postpartum depression.

One other concept that emerged from this study was that of women's initiative regarding their own mental health. The proposition regarding this issue was that the more a woman takes care of her own physical and emotional needs the greater is her sense of

well being and the least she would be likely to relapse into depression. A study may be designed where women who have had PPD are followed and assessed for the degree of self-care. The hypothesis would be that women who consistently take care of themselves relapse less into depression and perceive themselves as more emotionally healthy. The role of self-care may be further explored by comparing a group of non-depressed mothers with a group of postpartum depressed mothers in terms of their self-care behavior. In general, more research is needed that would compare groups of depressed and non-depressed mothers on variables like perceived support, sense of isolation and helplessness versus resourcefulness etc.

The relationship with the partner was a recurrent theme in this study and played an important role in the women's experience during PPD and her sense of well being and hopefulness once she has come out of PPD. Future research should further explore the issue of couple relationship and the complex association between the quality of the relationship and postpartum depression. Some of the hypotheses in such studies may be as follows: 1) there will be a positive relationship between a woman's perceived emotional closeness with her partner and her sense of well being following the experience of postpartum depression, 2) There will be a positive relationship between a woman's perception of pre-birth closeness with her partner and her perception of closeness upon recovery, 3) There will be a positive relationship between a woman's satisfaction from conjoint therapy and her perceived emotional closeness to her partner, and 4) There will be a positive relationship between a woman's perception of emotional closeness with her partner and her overall sense of well being.

Finally, the participants in this study went through a process of redefining self whereby they sensed a significant change in their selves following being depressed, mostly for the better. Further research is needed to explore this phenomenon. As discussed previously in this chapter, there is some evidence that women go through a process of redefining self, following the transition to motherhood. For example, studies may focus on the similarities and differences between mothers who become and mothers who do not become depressed following childbirth in relation to the process of redefining self. When examining the depressed group, is there a difference between women who undergo therapy and women who only receive medication and if so, what is it? The hypothesis in such study may be that women who have a successful experience of therapy during PPD will go through a process of redefining self that they will perceive as more positive than will women who either have a negative or a benign experience of therapy or do not receive therapy at all. Lastly, a woman who believes that she played an active role in her self-redefinition will perceive her redefined self as more positive than will a woman who perceives her redefined self as a result of being passively affected by postpartum depression. When studies like the ones proposed here are conducted and some answers to these important questions are provided, it may become possible to develop a grand theory in the area of postpartum depression.

Implications for Practice and Policy Making

One of the parameters of a well-developed substantive theory is its relevance for practice (Glaser, 1978; Strauss & Corbin, 1998), and in this case to the practice of psychology. The theoretical model that I developed in this study including the emerging propositions, albeit grounded, should be viewed as suggested, not proven (Glaser, 1978;

Glaser & Strauss, 1967). Nevertheless the experiences of the women who participated in this study may help illuminate the experience of others. The implications are tentative until further research confirms, alters adds to or refutes the findings of this study.

Perhaps the most important guideline for practitioners is simply that they should become aware of the existence of postpartum depression, its symptoms and the appropriate treatments for it. Some of the participants in this study turned to physicians, counsellors and psychologists for help and were misdiagnosed and thus often received inappropriate help or no help at all. On the other hand it was often the case that when professionals were able to diagnose the women and help them become aware and get treatment for postpartum depression the process of coming out of the depression began soon thereafter. Clinicians may therefore be advised to educate themselves in this area so that they are able to at least make a correct assessment of a woman with PPD. If they do not feel competent enough to offer her treatment they should refer her to another professional who is experienced and competent in this area.

As well, practitioners should use normalizing with care. While sometimes appropriate, normalizing can be inappropriate in treating women with postpartum depression because the women may perceive it as dismissive and minimizing. It is also incorrect to normalize postpartum depression as a phenomenon that most mothers experience because research indicates that only 10-16% of recently delivered women become clinically depressed and because the women themselves may feel dismissed if their experience is normalized and thus trivialized. On the other hand, normalizing may be used to reassure a woman that the symptoms she has been experiencing are common within the group of postpartum depressed women. An example that came up quite often

in this study was having thoughts and images of harming the baby and a participant that was having them described how relieved she was to hear that it was common among PPD women. A therapist may ask a woman if she is having these thoughts and if she is, they may inform her that many women with PPD experience these thoughts and often find them disturbing and horrifying. A therapist may suggest that having these thoughts indicates that the woman could benefit from treatment but that she is not to be blamed for having them and that it does not indicate that she has a character flaw, is inherently bad or that she is 'going crazy'. Rather, these obsessive thoughts are one of the well-documented symptoms of postpartum depression.

Many of the participants who were overwhelmed by depression, anxiety and obsessive thoughts ended up disowning themselves or, in other words, hated and 'turned their backs' on themselves. The therapist may be well advised to work with a woman who has postpartum depression on the issues of guilt and shame and promote self-acceptance. Self-acceptance was one of the conditions that existed for women in this study who managed to stay well following their breaking out of the depression. Another important condition that existed for these women was self-care. In order to become and stay well women engaged in self-care by making sure their emotional and physical needs were met and by redefining their personal freedom. This is one of the areas that a therapist may be able to help a postpartum depressed woman to work on. First, by illuminating the benefits of self-care for her own mental health and the welfare of her children and second, by empowering her to take action and start to self-care.

The relationship between the women and their children was another significant issue that came up for the participants in this study. There was a lot of expressed guilt,

disappointment and regret about the way these relationships had turned out. Therefore it may be important to explore this issue in therapy. Also, the challenge of balancing child needs and self-needs was one that the women often struggled with. The therapist may be able to help such women balance these two sets of needs that are often perceived to be contradicting, but may be reframed as complimentary.

The relationship with the partner was a recurrent theme in this study. All of the participants reported these relationships as having been adversely affected by the depression. As well, couple relationships that the women perceived as having been not very close and strong before the depression often remained damaged following the woman's recovery, which negatively affected the woman's sense of well-being. Also, women whose relationships with their partners eventually got better perceived themselves to be happier and more positive about the future than did women whose relationships did not improve. Therefore, involving the partner in therapy is of great importance, especially if the woman indicates that she experiences relationship problems and/or if she reports having had a somewhat alienated relationship with her partner prior to having a baby. It was suggested by the findings of this study that a positive conjoint therapy experience may result in couple closeness and a woman's sense of well being. As with any other types of treatment the therapist is well advised to refer clients to another therapist if they are uncomfortable with conducting conjoint sessions or if conjoint therapy is outside their area of expertise.

The women in this study underwent a process of redefining self through the experience of postpartum depression. Women who perceived their experience of therapy as constructive defined their redefined self more positively than women who were

unhappy with their experience of therapy or did not undergo therapy at all. As well, women who perceived themselves to have had a proactive role in the process of redefining self defined their changed self as more positive than women who experienced to have been passive in the process. Therefore it is important to encourage women to take an active role in the process of redefining self. It may be worthwhile to point out times and actions that the women may have attempted to be proactive but because of circumstances may have failed to achieve the desired outcome. In other words, this study suggests that women may fare better with a therapeutic philosophy and practice whereby the therapist is a consultant that helps the client access their own strengths and thus help themselves.

Finally, I would like to point out the importance of prevention. None of the women who participated in this study was aware of postpartum depression before they have been depressed themselves. Educating expectant parents about PPD may help to prevent it in some cases. For those who will get depressed, education would probably save a lot of time of being depressed without getting help. Education for partners of expectant mother may prove to be helpful in early identification and reaching out for professional help. Also, as the conditions prior to the onset of depression were identified in this study as being denial of self and isolation, women may well be advised to make sure they have some support network in place before the birth, and a plan to assure the fulfillment of their own needs following the birth. Finally, the women in this study did not reach out for help for a long time after they became depressed. Depressed women may be too overwhelmed and/or too ashamed of their situation to ask for help. Therefore, postpartum women should not be expected to reach out for help. Rather, there needs to be

a screening system in place to assure the early identification and treatment of women who become depressed following childbirth. Public health policy should be advised accordingly and would do well to adopt a prevention policy for childbearing women and their families.

Concluding Remarks

The contribution of this study is the elucidation of women's experiences of PPD as well as the development of a substantive theory of women's experiences of postpartum depression. The theory explains the social-psychological process of the experience of postpartum depression. Postpartum depression is conceptualized as a complex process in which the woman and the depression have reciprocating roles, i.e., the woman impacts on and is impacted by the depression. This process occurs within the context of the woman's life situation.

The theoretical framework that emerged from this study identified PPD as a six-phase process within which the woman becomes depressed following having a baby and eventually comes out of the depression. Through this process the woman also experiences a redefinition of her self. The relationship with her partner has been identified as a major part of the woman's experience of postpartum depression.

By listening to women who have gone through the experience of PPD and by utilizing the grounded theory method (Glaser & Strauss, 1967; Strauss & Corbin, 1998) I was able to develop a substantive theory that was grounded in the data. The grounded theory research method was utilized to allow the women's voices to be heard. At the same time it allowed me to conceptualize their experience in a theoretical model that may be helpful in understanding postpartum depression. Finally, the theoretical model that

was developed in this study may help to generate more research in this area and eventually a more refined theory on the experience of postpartum depression.

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Appendix A
(A call for participants)

Have you experienced
Depression after childbirth?

Has any of your immediate family members or friends experienced it?

I am conducting a study on the experiences of women who have become depressed following childbirth. I am looking for women who have had the experience and have come out of it who would be willing to share their stories with me. Primarily, I am interested in women's thoughts and feelings during the time of the depression and when they were no longer depressed. Also, their ways of coping with the situation, and what happened in their families before, during and after the depression.

The total time commitment would be around three hours, divided between two separate meetings. Participating in the study is not going to be a counselling situation, but rather, an opportunity for sharing your story for the purpose of research, which may inform the practice of counselling as well as future research. Insight into one's own personal development may be gained in the process, as well as the reward of contributing to the development of a theory of depression following childbirth.

The researcher is a Ph.D. candidate in the counselling psychology program at UBC, is a mother of three, and has experienced depression following childbirth.

If you are interested in participating in this study, or would like further information, please call xxx-xxxx and ask to speak to Michal.

APPENDIX B

Consent Form

The title of this study is "Toward a theory of Postpartum depression in the context of women's lives." The purpose of the study is to explore the experiences of women who became depressed following childbirth, as well as the experience of their close family members and friends. The study is part of Michal Regev's Ph.D. studies at the University of British Columbia. If you wish to verify that Ms. Regev is a student at U.B.C., and that this is an approved research project, please call Dr. Bill Borgen at 822-5261.

If you choose to take part in the study, you will be interviewed once for about two hours. In a second meeting, which will take up to one hour, you will be presented with a summary of the first interview, which you will be asked to verify, comment on and /or add to. Your identity will be kept confidential. You have the right to stop the interview, refuse to answer certain questions or withdraw your participation at any time and without any consequences. In order to keep track of the information you agree to provide Ms. Regev will be tape-recording the interview. The tape will be transcribed onto paper and all details that could identify you will be removed. The tapes will be kept in a secure place and will be erased once the study has been completed.

Ms. Regev will be responsible for interpreting the interview and writing the final report of this study. Any published reports of this study will acknowledge the contribution of those who participated in it without revealing their identity. These reports will be available to you upon request. If you have any questions about this project, please ask Ms. Regev to answer them before signing this consent form.

If in agreement with these terms, please sign below.

I, _____, have read and understood the above statements and agree to the terms outlined in them. I have received a copy of this consent form. By signing below, I agree to participate in the study.

Signature _____ Date _____

APPENDIX C

Initial Interview Guide

1. Maybe you would like to start by telling me about your experience of depression following childbirth
2. What preceded the pregnancy? What was your relationship with your partner at that time?
3. What was your pregnancy like? How would you describe your mood throughout the pregnancy?
4. What was your experience of the birth?
5. What was your experience after the birth?
6. How was your mood at the time, and when did you start feeling depressed?
7. Tell me about your baby.
8. How have you coped with your situation? What helped and what hindered your coping?
9. How has your relationship with your partner been after the birth?
10. How has your relationship with your baby been?
11. Were there any other people with whom you have had a significant relationship that you would like to talk about?
12. Is there anything that we haven't covered that you would like to tell me about, or that you think may add to the understanding of your experience of depression after birth?

APPENDIX D

Revised Interview Guide

1. Maybe you would like to start by telling me about your experience of depression following childbirth
2. What was your relationship with your partner before and during the pregnancy? What was your pregnancy like? How would you describe your mood throughout the pregnancy?
3. What was your experience of the birth?
4. What was your experience in the weeks following the birth?
5. How was your mood at the time, and when did you start feeling depressed?
6. Tell me about your baby.
7. How have you coped with your situation? What helped and what hindered your coping?
8. How has your relationship with your partner been after the birth?
9. How has your relationship with your baby been?
10. Are there any other people like family members or friends who you would like to talk about with regards to your experience?
11. Is there anything that we haven't covered that you would like to tell me about, or that you think may add to the understanding of your experience of depression after birth?

APPENDIX E

Participant Demographic and Background Information

Participant's Initials _____

Age _____

Ethnic Background _____

Marital Status _____

No. of years in the relationship _____

Number of Children _____

Children's ages _____

Level of Education Completed _____

Occupation Before the Birth _____

Current Occupation _____

Describe your financial situation in one or two words _____