OUT OF THE DARKNESS AND INTO THE LIGHT:
WOMEN'S EXPERIENCES WITH DEPRESSION AFTER CHILDBIRTH

by

KATHY LYNN BERGGREN-CLIVE

B.A., The University of Victoria, 1980
B.S.W., The University of British Columbia, 1981

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SOCIAL WORK

in

THE FACULTY OF GRADUATE STUDIES
School of Social Work

We accept this thesis as conforming to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA
May, 1996

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Department of  

Social Work  

The University of British Columbia  
Vancouver, Canada  

Date  June 3, 1996
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Women's Experiences with Depression after Childbirth

ABSTRACT

While becoming a mother can be a fulfilling and joyful experience, 10-28% of women can be affected by an intense emotional response commonly called postpartum depression. This phenomenon is distinguishable from the "transitory baby blues" and is often characterized by crying, confusion, fatigue, depression, insomnia, difficulty caring for the baby and self and suicidal thoughts. Research on postpartum depression has largely concentrated on investigating its possible causes and predictors utilizing quantitative methodology. Women are the experts of their own lives yet, their voices with respect to the existing body of knowledge about depression after childbirth are missing. In this exploratory qualitative study, I utilized a feminist perspective and interviewed eight women who had recovered from postpartum depression, thus allowing them to define the nature of their experiences. A three-stage model emerged that demonstrated how women made sense of that time in their lives. Why did this Happen?, the first stage, represented women's attempts to determine why they had postpartum depression. The second stage, Spiralling Downward, focused on how the depression entered their lives and enveloped them in darkness. Getting to the Other Side, the third stage, addressed the process of their recovery. The findings of this study provides a contextual picture of women's experiences with depression after childbirth and the knowledge created has important implications for the practice of professionals and the implementation of policy and programs that meet the needs of new mothers and their families.
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Acknowledgments

This paper is dedicated to the eight women who participated in this study. I would like to express my gratitude for your commitment to this project and for the courage, honesty and trust that you displayed throughout our time together. I will make every effort to ensure that your stories reach beyond the pages of this thesis.

I would also like to recognize my sister, Brenda. She experienced postpartum depression with both of her children. It was her story of despair and triumph that inspired me to find out more about this phenomenon that affects many new mothers.

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Introduction

My interest in the area of postpartum depression is derived from both professional and personal experience. Professionally, I work in the parent education field and I find that most of my contacts are with women and children. Over and over again, women express both the joy and ambivalence of being a mother. Motherhood is somewhat paradoxical; women feel that mothering should be natural and fulfilling yet the work associated with the role of mothering is overwhelming and exhausting while seldom recognized or valued by our society. On a more personal level, I am a mother and I find that my own experience with mothering is often a source of contradiction and discontent; how can I feel such an incredible love for my children and yet at the same time, how can I feel such resentment towards the work and the responsibilities associated with raising my children? Finally, the driving force behind my interest in depression after childbirth came from my sister who experienced postpartum depression after the birth of both of her children. Her frustration and her strength in the struggle to overcome such misery and despair inspired me to pursue the phenomenon in more depth.

Many assumptions about motherhood serve to create a picture of happiness and anticipation accompanying the birth or adoption of a child. A family awaiting the arrival of a child experiences emotions ranging from sheer pleasure and delight to intense fear and nervousness. Society is also quite clear about what parental emotions should be experienced once the baby is born. Feelings of satisfaction, joy and pride are communicated through magazines, television, movies and newspapers. Family and friends tell women to relax and enjoy the most wonderful time of their lives. The arrival of a child and the intensity of the feelings that accompany this transition are like no other life experience. The reality, however, is that parenting is a monumental task and the enormous physical and emotional changes that accompany the birth of a new baby are often unrecognized and unsupported.
For many women and their families, the transition to parenthood turns out differently than they had expected. "Nobody ever told me it would be like this" has been echoed by many new mothers as the physical exhaustion, role changes, responsibilities, social isolation and shifts in the couple relationship begin to take its toll. Women begin to feel guilty and inadequate because they are not responding to motherhood as they feel they should. At the same time, rather than express the negative feelings they may have towards this wonderful but overwhelming experience, many women live in silence and despair because they fear disapproval and criticism. For some women, these negative feelings become so intense and distorted that it can adversely affect not only the mother's self-perception and world view, but also her relationships with her infant and her partner (Fleming, Klein, & Corter, 1992, p. 686). The postpartum period is the time in which women are at highest risk for developing such emotional reactions and should these problems occur, they often go undetected until they become very severe. Postpartum emotional reactions are a common consequence of childbirth and it is essential that the symptoms be recognized and monitored so that women can receive the necessary information, support and treatment.

Many women will experience postpartum depression after the birth of their child and may seek assistance from health care professionals. The "diagnosis" and "treatment" of postpartum depression tends to be dominated by the medical model which suggests that postpartum depression is indicative of individual pathology. Hormonal fluctuations or flawed personality traits are seen to be the causes while medication and individual psychotherapy are viewed as the treatments. I believe that this viewpoint does a great disservice to women as it fails to recognize the social construction of the institution of motherhood. Rossiter (1988) states that women then frame their difficulties as mothers as personal inadequacies but do not look at why they were unprepared or why they feel inadequate. In other words, the emotional and physical exhaustion associated with the mothering role is not taken into consideration.
A feminist analysis of postpartum depression would seek to identify women's roles in a patriarchal society and address issues that concern the subordination and oppression of women in everyday life. Feminist literature is already acknowledging motherhood and its wider implications as a central feminist issue (Oakley, 1980; McCannell, 1986; Rich, 1986; Rossiter, 1988; Thurer, 1994). I would take this one step further and argue that postpartum depression is not a pathological disease, but a natural response to the myths of motherhood constructed in a patriarchal society. A feminist analysis would challenge the prevailing assumptions that motherhood is an inherently "natural" and "satisfying" experience for all women.

Feminist perspective and feminist research are not familiar concepts within the medical world which allows no place for listening to the voices of women themselves. Silencing women's voices and failing to listen to what women have to say about their own condition has resulted in mothers being isolated with their distress. It is essential that postpartum depression be understood in terms of women's experiences and that their accounts of their own lives be accepted as "knowledge". The best way to achieve this goal is to conduct feminist research utilizing qualitative methods.

The current literature and research on postpartum depression is diverse and contradictory and is predominated by a quantitative paradigm. The use of quantitative methods results in the pursuit of discovering what is the "objective truth" about the matter rather than attempting to understand women's accounts of their own experience. Few studies have reported any qualitative data that acknowledges the voices and the words of the women themselves. Additionally, there is a lack of a feminist perspective and research with respect to depression after childbirth. Thus, the intent of my research is to conduct an exploratory qualitative study utilizing feminist principles. My research is designed to hear women's voices; their voices of pain, struggle and triumph. Women's stories and accounts of their experiences with depression after childbirth can provide important insights for anyone wishing to provide assistance to mothers. The current state of the
literature offers a wealth of information with respect to the cause and the treatment of depression after childbirth. Women's voices, however, are missing in terms of these issues. This study will provide women with the opportunity to talk about issues such as; what the experience was like for them; what they think were the contributing factors; what helped them to recover; what they would tell professionals; and what advice would they give to other women having a similar experience.

Chapter One seeks first to demystify the plethora of terminology and definitions of postpartum depression. Additionally, it contains a literature review of the medical model and sociological model as related to the existing research on causes and predictive factors of postpartum depression. Chapter Two presents a feminist critique of the medical model and outlines the limitations of quantitative research on postpartum depression. An argument for the use of qualitative methods is advocated and an overview of the existing qualitative research on postpartum depression is presented. Additionally, there is a discussion of a feminist approach to postpartum depression including a presentation of feminist research studies in the area of postpartum depression. Chapter Three presents a more comprehensive theory of postpartum depression that incorporates a feminist analysis and critique of the effects of the political economy on the development of the ideology of motherhood. This chapter looks to find the causes of depression in the structure of society. Chapter Four presents a feminist research project that utilizes qualitative methods and seeks to discover how women who have recovered from postpartum depression make sense of that time in their lives. Chapter Five presents the findings of the research study. The working model that emerged through the data analysis is presented and supported with verbatim quotes from the eight women who were interviewed. Finally, Chapter Six contains a discussion the relationship between the findings and the existing body of literature. This chapter further explores the implications of the research in relation to practice and policy considerations and future research.
Chapter One

Definition, Causes and Predictors of Postpartum Depression

In this chapter, I will examine the existing state of the literature and provide a comprehensive definition of the phenomenon of postpartum depression. In addition, I will present an overview of the current research literature as it relates to the causes and the predictors of postpartum depression.

What is Postpartum Depression?

It is important to realize that a spectrum of emotional reactions and symptoms appear to be common in the postpartum period. Confusion arises, however, when the term postpartum depression is used to describe the full range of emotional reactions from a new mother's constant tearfulness to the rarer thoughts of harming the baby. Postpartum depression is, in itself, one of the emotional reactions that can effect new mothers. It is helpful to picture a continuum which includes the baby blues, normal adjustment, postpartum depression, postpartum anxiety reactions (panic attacks and obsessive-compulsive behavior) and postpartum psychosis. A more accurate term to describe these phenomena may be postpartum emotional reactions.

The earliest and mildest of these reactions is the "baby blues" with symptoms including insomnia, tearfulness, irritability, anger, anxiety, exhaustion, appetite disturbances and tension. (Kennerley & Gath, 1989; O'Hara, 1991; O'Hara, Schlechte, Lewis, & Wright, 1991). Symptoms of the blues typically peak three to five days after delivery (Kennerly & Gath, 1989; O'Hara et al., 1991). The reported prevalence rates are variable ranging from 26% to 85% (Thirkettle & Knight, 1985; O'Hara, 1991). The baby blues is a brief, temporary moodiness that usually resolves itself within a few days. In the past, researchers have often overlooked the significance of the blues. Hapgood, Elkind, and Wright (1988) suggest that the blues may predict later postpartum depression and for this reason the blues are worthy of more research.
The next emotional reaction falls between the relatively minor baby blues and postpartum depression in terms of seriousness. When a new mother settles at home with her baby, she experiences a set of new demands; this constitutes the normal postpartum adjustment (Dunnewold & Sanford, 1994). The term "normal", however, should not lead to the conclusion that this is an easy period. In fact, Kleiman and Raskin (1994) call this time, the postpartum stress syndrome to emphasize the huge changes a woman faces in the early weeks of motherhood. This reaction has only recently been recognized in the spectrum of postpartum emotional reactions. These women, however, may get lost in the shuffle when describing postpartum adjustment reactions because the symptoms are not as striking as those exhibited in postpartum depression (Kleiman & Raskin, 1994; Dunnewold & Sanford, 1994). Postpartum adjustment is an extension of the blues. In other words, if women are beyond the time frame for the baby blues and are still experiencing negative feelings, they have probably moved along the continuum into postpartum adjustment. Most new mothers experience some degree of adjustment; however, the amount of difficulty that they may have depends on a variety of factors related to this new transition. Women will encounter periods of crying, fatigue, irritability, sleep disturbances, appetite changes, tearfulness, anxiety, doubts about their parenting and experiencing feelings of unattractiveness. In postpartum adjustment, women continue to function fairly well. Their coping skills are still intact and as a result, no one around them notices how they are feeling. However, if the symptoms persist past two to five weeks and the difficulties begin affecting the woman on a daily basis, then it is possible that the mother has reached the next step on the continuum of postpartum emotional reactions; postpartum depression. There is no research that reflects occurrence rates for the newly identified emotional reaction of postpartum adjustment. However, it is extremely important that the difficulties and feelings associated with postpartum adjustment are now recognized and discussed in the literature because it is during this
period that women may require extra support and practical help to prevent the
development of postpartum depression.

Postpartum depression is often difficult to differentiate from the above mentioned
adjustment reaction because many of the symptoms are similar. The difference, however,
is that the symptoms seem to affect the women most of the time rather than just some of
the time. Often, women have lost the ability to use their coping skills and there are strong
feelings of helplessness and hopelessness about their situation. Postpartum depression has
an onset anywhere from three weeks to one year postpartum with symptoms ranging from
mild to severe (Millis & Kornblith, 1992; Cox, Murray & Chapman, 1993). Due to the
discrepancies with regard to the exact definition of postpartum depression there are some
inconsistencies with respect to prevalence rates. Research indicates that it can affect
between 10 and 28 percent of women with new babies (O'Hara, Neuaber & Zeloski, 1984;
Cooper, Campbell, Phillips & Bond, 1988; Gotlib, Wallace, Whiffen & Mount; 1989;
O'Hara et al; 1991; Cox et al., 1993). Episodes are variable in duration, lasting anywhere
from a few weeks to many months (Chalmers & Chalmers, 1986; Cox et al., 1993).
Postpartum depression is characterized by depression, difficulty caring for the child,
crying, confusion, fatigue, feelings of inadequacy, sleep disturbances, forgetfulness and
suicidal thoughts (Affonso & Arizmendi, 1986; O'Hara, 1987). While postpartum
depression most often occurs as a primary illness, the recent literature indicates that two
anxiety disorders can either accompany or follow postpartum depression. While the
postpartum anxiety syndromes are not as well studied as postpartum depression, both
panic disorder and obsessive-compulsive disorder are present in about two percent in the
general population, and both may be first diagnosed after childbirth, or exacerbated by it
(Kleiman & Raskin, 1994; Dunnewold & Sanford, 1994; Robinson, 1994). Anxiety and
panic reactions may occur without depression. Women who have anxiety reactions worry
a great deal, may have frightening thoughts which they feel unable to control (this pattern
is called an obsessive-compulsive disorder), or have panic attacks. Specific figures are not
yet available on the numbers of women experiencing these reactions because it is only recently that researchers have identified these as distinct diagnostic categories.

Postpartum psychosis is a severe disorder that usually begins within the first three weeks postpartum but can occur as late as eight weeks postpartum (Kendall, Chalmers & Platz, 1987). It is very rare that postpartum depression can develop into a psychosis. Kendall et al. (1987) found that postpartum psychosis occurs in 2.2 of 1000 births. Women experiencing psychosis exhibit tearfulness, sleep and appetite disturbances and confusion. Bizarre delusions about the infant being dead or defective, hallucinations, and a lack of insight are the most severe features in postpartum psychosis (Thirkettle & Knight, 1985; O'Hara, 1991). Postpartum psychosis seems to be readily definable in the literature.

Now that I have provided an overview of the range of emotional reactions after childbirth, I will focus on further discussion about postpartum depression, the specific reaction on the continuum that is the subject of my research. Postpartum depression is the term commonly used in both professional and popular literature. Postpartum psychiatric disorder, postpartum mental illness and postpartum mood disorder are the terms used in the medical and mental health fields. This language is often used synonymously with postpartum depression and has a precise meaning within these two disciplines; an incessant and intense sad, empty feeling, or the mood disorder called clinical depression, which is characterized by this feeling for two or more weeks (Kleiman & Raskin, 1994, p. 4). In short, postpartum depression means that after childbirth a woman exhibits the emotional and physical symptoms of clinical depression (Kleiman & Raskin, 1994, p. 4).

It must be noted, however, that there is an ongoing debate as to whether postpartum depression resembles clinical depression found in the general population or whether its qualities are unique to women and the childbearing experience. Features that do distinguish postpartum depression from general depression include greater anxiety and irritability, the rare occurrence of suicidal thoughts, worsening of mood in the morning
rather than evening, and early rather than late insomnia (Hopkins, Marcus & Campbell, 1984). Subsequently, there is ongoing controversy as to whether or not postpartum depression should be a distinct diagnosis in the DSM-IV (Purdy & Frank, 1993; Whiffen, 1992). Women's experiences with mood and emotional changes during childbearing are frequently reduced to fit an identifiable diagnostic category of depression. In the DSM-IV, a postpartum onset specifier can be applied to the current Major Depressive, Manic, or Mixed Episode of Major Depressive Disorder, Bipolar I, or Bipolar II or to Brief Psychotic Disorder if onset is within four weeks after delivery of a child (p. 302). Affonso (1992) believes that the affective changes and emotional disturbances experienced by childbearing women can be dismissed as unimportant when classified as a category of mental disorder. Also, the DSM-IV specifies "onset within four weeks after delivery" which does not take into consideration those women who develop postpartum depression after that time frame. Other investigators assert that a continuity exists between postpartum depression and other depressions. Whether postpartum depression differs in any other way from depression at other times of life remains unclear. Affonso (1992) suggests that depression in childbearing women may be of a different nature or character that necessitates exploration of unique symptom constellations which dictate alternative treatment outside the realm of standard psychotherapy and antidepressant medications. While the DSM-IV seeks to recognize the implication of social factors in its application, it still operates within a medical model which assumes that there is a biological or psychological malfunctioning within the person which in turn, indicates that it is an individual issue.

For the purpose of further discussion and to maintain congruency with the majority of literature, I will use the term postpartum depression to name the various range of emotional reactions other than psychosis and the baby blues. I also chose to use this term because this is the phrase that the women in the study felt best described their experience. I would like to augment this statement with the viewpoint that I have great
discomfort with the term postpartum depression. However, I have not yet discovered a word or phrase that accurately reflects the emotional distress that can accompany motherhood. I will use the phrases, depression after childbirth, emotional reactions after childbirth and emotional reactions to motherhood interchangeably with postpartum depression as these terms more accurately reflect the fact that emotional distress can occur any time after childbirth and not within a specified time frame as is implied with the word postpartum. I am not overly concerned about differentiating between adjustment and postpartum depression because I believe that any emotional distress associated with the transition to motherhood must be taken seriously and not slotted into a particular category.

**Origins of Postpartum Depression**

While postpartum emotional reactions have been recognized since the time of Hippocrates and studied for more than a century (Steiner, 1990), a review of the literature indicates there are discrepancies about the exact definition of postpartum depression. Dobie and Walker (1992) state that agreement on definition is important for accurate, relevant, and reproducible research. Consequently, there are many inconsistencies in the existing research on postpartum depression. I immersed myself in the literature and discovered that over the years, research has embarked in numerous directions with respect to the study of postpartum depression. There has been a progression from looking at prevalence and etiology to identifying predictors or factors that may predispose a women to postpartum depression. The hope is that if there are particular risk factors, then preventative interventions can be developed; however, there is very little that can be answered with much confidence. Postpartum emotional reactions have been described as elusive and controversial and this is certainly supported by the diverse opinions and conflicting research results in the literature.

Within the existing body of research, the findings regarding the causes and correlates of postpartum depression are divided into two explanatory frameworks.
Mauthner (1995) and Nicolson (1990) have identified the medical-psychiatric approach that defines the mothers as being "ill" and seeks to identify hormonal and psychological causes and the sociological perspective which suggests a particular vulnerability to a variety of different social factors. Quantitative methods have been the primary source of inquiry and I will now present a literature review related to the two explanatory frameworks.

**The Medical-Psychiatric Perspective**

For the purposes of this paper, the medical model will be viewed as encompassing both the fields of medicine and mental health. In medicine, postpartum depression is perceived as an illness or a disease precipitated by biological malfunctioning and to be dealt with by prescribed treatments ranging from hospitalization to drug therapy. The fields of psychiatry and psychology emphasize how mood and behavioural changes are emotional disturbances that can lead to a mental disorder. Mechanic (1989) states that the concept of mental illness can be characterized by an underlying biological dysfunction and/or deviations in behaviour, thinking and affect. Both the medical and mental health perspectives emphasize that the condition is located within the individual and that the individual must be "cured".

**Physiological Causes**

It has been acknowledged that postpartum depression may, in some cases, be a physiological phenomenon precipitated by endocrine changes and hormonal imbalances (O'Hara, 1991; Harris, 1993). The biochemical changes that occur during pregnancy, childbirth and the postnatal period must be featured in any comprehensive understanding of postpartum depression. It has been suggested that radical changes in estrogen and progesterone levels that follow childbirth are linked to depression. When one considers the extent of hormonal changes that occur during the menstrual cycle, it would not be surprising that the far greater changes during pregnancy and after labor would have a profound emotional effect. Female reproductive hormones have significant effects on the
brain chemicals or neurotransmitters. If the neurotransmitters are out of balance, then this can be a precipitator of depression (Kleiman & Raskin, 1994). It is suggested that some women may be more sensitive to these sudden physiological shifts because of genetic predisposition. The shifts may cause an imbalance of the neurotransmitters, norepinepherine and serotonin (Millis & Kornblith, 1992). Dalton (1992) suggests that progesterone, a hormone supplement, be administered to women who have previously suffered from postpartum depression. However, it must be noted that while women will experience hormonal changes with childbirth, not all women develop postpartum depression. Also, it has been reported that postpartum depression has affected adopting women and fathers as well (Kleiman & Raskin, 1994). This fact would certainly lead to a questioning of the significance of the physiological factors. To date, the literature indicates that while there certainly are biological changes that occur with childbirth, there is no consistent evidence that supports that these hormonal changes cause postpartum depression among women. (George & Sandler, 1988; O'Hara et al., 1991). While a physiological orientation is necessary to complete the picture puzzle of postpartum depression, it is important to appreciate its limitations in answering questions about women's health and behaviors. This perspective tells very little about how women are affected by depression and what preventative measures can be developed to help women.

Pregnancy and the postpartum period are sometimes accompanied by changes in thyroid function. Studies are emerging which have examined thyroid disorder and depressed mood in the year following delivery (O'Hara, 1991; Harris, 1993). The thyroid gland is affected by childbirth and it is known that low thyroid functioning can cause depression (Kleiman & Raskin, 1994). Therefore, it is possible that thyroid problems could be masked as postpartum depression and it is important for women to determine if a thyroid dysfunction could be the reason for the depression.

There are theories that link a family history of depressive symptoms, previous postpartum depression or depression during pregnancy to the onset of postpartum
depression (O'Hara et al., 1984; O'Hara & Zeloski., 1990; Gotlib et al., 1991; O'Hara et al., 1991). However, O'Hara (1991) found that most women who had a depression before childbirth did not experience problems with postpartum depression; however, they are at increased risk especially in its interaction with other stress variables. Gotlib et al. (1991) and Laizner and Jeans (1990) found that those women who were diagnosed as depressed in the postpartum period exhibited higher levels of depressive symptomology during pregnancy. However, the research findings are contradictory.

Psychological Causes

Many researchers have concentrated on psychological theories of depression. Psychoanalytic theories developed in the 1930's and the literature of this period characterize women as having numerous issues. In the case of postpartum depression, Affonso and Domino (1984) in their review of the literature, identified the following as concepts which could be used to explain postpartum depression:

1) Frustration of oral needs during pregnancy
2) Pregnancy as a regressive, narcissistic state
3) Pregnancy creating regression of the ego and loss of ego control
4) Perceived loss of the symbiotic relationship with the fetus through birth
5) Unresolved oedipal conflicts with the introjecting of hostility to one's mother.
6) Conflictual identification with one's mother.

They concluded that these theories cannot be empirically tested, but may be helpful in understanding the depression. Some early studies were done that suggested that the quality of the woman's relationship with her own parents or a history of early separation from parents were predisposing factors to postpartum depression (Paykel, Emms, Fletcher, & Rassaby, 1980; Watson, Elliott, Rugg, & Brough, 1984). The findings, however, found no association between parental conflict and childhood separation from parents and postpartum depression. A more current study by Gotlib et al. (1991) found
that negative perceptions during pregnancy of maternal and paternal caring during childhood were associated with diagnosis of postpartum depression.

Cognitive theories suggest that personality characteristics and distorted thought processes predispose certain women to postpartum depression. Anxious, controlling, perfectionist, and compulsive individuals are thought more likely to have unrealistic expectations of childbirth and parenting (Hopkins et al., 1984). Thus, according to cognitive theorists, the women's disappointment from not meeting their own or others' expectations may lead to feelings of failure and distortions of thought which subsequently can lead to depression after childbirth. Affonso et al. (1991) identified negative thought patterns or cognitive style as a predictor of postpartum depression; however, other findings do not link negative affect with increased risk for postpartum depression (Whiffen, 1988; O'Hara et al. 1991). Low self-esteem has also been directly linked to postpartum depression. Affonso and Arizmendi (1986) found that a woman's view of herself and her future was significantly related to whether she was likely to be depressed. Women who had frequent doubts about their ability to handle the demands of parenthood tended to exhibit depressive symptoms.

O'Hara (1987) looked at depressive attributions which are negative expectations and evaluations of events or situations that make them more stressful, and in turn, lead to depression. When applied to postpartum depression, this study suggests that women who expect to be helpless or who typically blame themselves may become depressed when confronted with stressors of pregnancy, delivery and childcare. However, research findings have been contradictory.

The authors of two studies (Donovan & Leavitt; 1989; Donovan, Leavitt & Walsh, 1990) looked at the attributional style that they referred to as illusory control. They described this as a sense of having control over events that, in reality, were beyond control. They discovered that when women found that they could not control the events
they thought they could, they then experienced guilt. In other words, when they could not be the perfect mother they thought they should be, they became depressed.

Physiological and psychological theories of postpartum depression have been inconsistent and contradictory in the findings. Hormonal and personality factors may ultimately be understood as playing a causal role in postpartum depression, but as yet the specific hormonal occurrences or personality traits that could put a woman at risk have not been identified.

**The Sociological Perspective**

More current research has shown that social and cultural factors play an important role in contributing to postpartum depression. Rather than provide a theory of postpartum depression, these factors can be seen as predictors or vulnerability factors.

The effects of the amount and nature of the support present when the new mother arrives home has been the subject of numerous studies (Gotlib et al., 1991, Small, Brown, Lumley, & Astbury, 1994; Lodgsdon, McBride & Birkimer, 1994). A woman's level of social support is perhaps the single most important factor to consider in the study of postpartum depression. Lack of practical, informational and emotional support from family, friends and a partner have been identified as one of the best predictors of postpartum depression. There are increased demands on women once they become mothers and the availability of social support is suggested to be a means by which to ease a woman's burden and increase her ability to cope with all the changes associated with motherhood. Husbands have been identified as the resource most frequently sought for help. Often the practical help and emotional support that might ordinarily be provided by a husband may be absent. O'Hara (1986) and Campbell (1992) found that women experiencing depression reported less practical and emotional support from their husbands. Thus, the question is raised about the correlation of marital satisfaction with postpartum depression. Poor marital relationship has been identified as the most
consistent psychosocial predictor of postpartum depression (Affonso et al., 1991; Gotlib et al., 1991; Hock, Schirzinger, Lutz, & Widaman, 1995).

Stressful life events occurring prenatally and postnatally have also been identified in the literature as predictors of postpartum depression (Kumar, 1984; Affonso and Domino, 1984; Hopkins et al., 1987; Whiffen, 1988; Affonso et al., 1991). Moving to a new home, starting a new job, financial problems or a death in the family may be stressors that contribute to depression in the postpartum period.

Stress related to labour and delivery have also been identified as possible predisposing factors in the occurrence of postpartum depression (Hopkins et al., 1987; Whiffen, 1988). Research examining the relationship between negative birth experiences and postpartum depression has yielded contradictory findings. Some have found that the use of obstetrical interventions is related to depression (Oakley, 1983; Thirkettle and Knight, 1985) while others have not (Chalmers and Chalmers, 1986; Knight and Thirkettle, 1987). O'Hara et al. (1984) found a relationship between birth complications and depression while Whiffen (1988) did not draw the same conclusion with her data.

Stress related to infant care has also been identified as a possible predictor in the development of postpartum depression (Hopkins et al., 1987; Whiffen, 1988). Maternal perception of difficult infant temperament is strongly related to mothers' level of postpartum depression (Cutrona & Troutman, 1986). The direct relationship between difficult infant temperament and maternal depression is thought to be based on multiple factors that include infant crying and colic, ambivalence toward the infant, unmet expectations as to the infant's nature and specific life-style changes associated with the care of a baby.

Lack of sleep and associated physical exhaustion may also be factors related to postpartum depression. Kendall-Tackett (1993) suggests that because fatigue is commonplace for new mothers, it has not been adequately studied in relation to postpartum depression. Lack of research exists despite observations that sleep
disturbances and fatigue, both symptoms of postpartum depression, interfere with a mother's abilities to cope with her responsibilities (Kendall-Tackett, 1993, p. 28). Fatigue can be likened to that of the chicken-and-egg type of question, not knowing which came first. Fatigue can be both a symptom and a cause of depression. Kendall-Tackett (1993) states that the lack of interest in fatigue as a cause of postpartum depression is surprising because sleep deprivation has been studied in relation to depression in non-postpartum men and women (p. 28).

The work of Stern and Kruckman (1983) lends support to a anthropological view of postpartum depression. These researchers examined parenthood across cultures and noted rituals for role transition as well as the availability of social support. They suggested that depression may represent more of a culture-bound syndrome resulting from lack of social structuring of the postpartum events, social recognition of the role transition for the new mother and support and assistance for the new mother. For example, certain cultures treat the postpartum period as a time of celebration that are socially dramatized by rites of passage and healing ceremonies. The postpartum period is a time when the vulnerability of women is recognized and practices such as social seclusion, mandated rest, assistance in all types of household tasks and infant care and recognition of a new social status are implemented.

The medical-psychiatric perspective and the sociological perspective encompass a multitude of potential causal or vulnerability factors for postpartum depression. No one factor has received unambiguous support in the literature; therefore, it becomes apparent that it may well be a combination of these factors that increase a woman's risk for postpartum depression.
CHAPTER 2
A Feminist Perspective of Depression After Childbirth

In this chapter, I will provide a definition of feminist perspective and how feminist thought can be applied to the phenomenon of postpartum depression. Next, a critique of the medical model will be presented which demonstrates the limitations of viewing women's emotional health after childbirth within such a narrow and oppressive framework. Additionally, the limitations of quantitative methods will be identified followed by a discussion of the recent shift towards the use of qualitative studies which explores women's experiences with depression after childbirth. A review of the literature with respect to those qualitative studies will be presented. I will conclude with a discussion of the need for the application of a feminist perspective to qualitative research and present an overview of the feminist research on postpartum depression.

Defining Feminist Perspective

Feminist thought or a feminist perspective will be utilized to explore the phenomenon of postpartum depression in order to provide an alternative way of understanding the nature of this problem that affects many women in our society. A feminist perspective recognizes a world in which women's voices and knowledge have been constrained, their contributions to society undervalued or ignored, and their potential in all facets of human endeavour stifled and suppressed (Chernomans and Rainonen, 1994, p. 2). This is what is referred to as oppression. While there are many schools of feminist thought (radical, liberal, socialist, psychoanalytic, postmodern) that vary in describing the source and process of women's oppression and the solutions to bring about social change, there are some ideas that are common to all. The following points are the tenets I have identified and adopted for this paper:

1. Women are seen to be oppressed through patriarchy or the system of male dominance over women. Social forces such as cultural values, ideologies, economic
forces and institutional structures initiate, support and legitimate that oppression. (Callahan, 1993; Chernomans & Rainonen, 1994).

2. At the heart of feminist critique is the challenge to theories and practices that ignore an analysis of power and gender (Callahan, 1993; Allen and Baber; 1992).

3. There is an assumption that, by identifying, describing and explaining the world as women see it, we can obtain a newer and fuller worldview (Farganis, 1994; Chernomans & Rainonen, 1994).

4. There is a valuing of women's voices and the recognition that women's subjectivity must be claimed as knowledge (Chernomas & Rainonen, 1994; DiQuinzio; 1993).

5. There is a recognition that issues of oppression are sensitive to the diversity and differences among women in terms of power associated with race, class, ethnicity, sexual orientation, occupation, education and so forth (Allen & Baber, 1992; DiQuinzio; 1993; Farganis, 1994).

6. In order to work towards the goal of empowering women and transforming unequal relations, a critical perspective must be adopted that deconstructs and reconstructs the commonly assumed aspects of social life for women (Allen & Baber, 1992; DiQuinzio; 1993; Allan; 1994).

Feminist thinking or a feminist perspective is about why women are oppressed and what can be done about it. This paper utilizes a feminist perspective and recognizes that where women have been omitted, they must be brought into the creation of new discourses. The experience of women must be placed at the center of inquiry rather than on the fringe. Thus, a feminist perspective when applied to depression after childbirth, explores and critiques the medicalization of postpartum depression. It further provides a broader analysis that demonstrates women's distress is a result of the symptoms of a larger social problem and advocates for the deconstruction and reconstruction of the ideology of motherhood. Finally, a feminist perspective provides a means by which to conduct
research on postpartum depression that breaks out of the androcentric mould and enables research that is for women rather than on women and further recognizes the diversity of women's voices and experience as integral in the creation of knowledge.

**Challenging the Medical Model**

Historically, the research on postpartum depression has taken place almost exclusively within medical and clinical settings and has been dominated by a medical paradigm, in which the feelings and emotions of women have been labeled as "postpartum depression" and pathologized as illness (Mauthner, 1993, p. 351). The medical model depicts a framework that encompasses both biological and psychological theories to explain the potential causes of postpartum depression. To date, the research remains controversial and contradictory. A number of feminist writers have critiqued and challenged traditional medical thinking and postpartum depression (Nicolson, 1986; Rosenberg, 1987; Ussher, 1992; Mauthner, 1993). They have suggested a number of limitations of the medicalization of depression after childbirth.

First, within the medical model postpartum depression is classified as a disease or as an illness. Women are labeled as mentally ill and this carries a social stigma for women. While biological and psychological factors are at play during the postpartum period, to what extent and in what way they contribute to postpartum depression is not understood. It is limiting to view postpartum depression within this framework and it is essential that social and cultural factors be considered in order to ensure that the social context of women's problems are not negated through the medicalizing of women's distress. In other words, there are understandable reasons why motherhood may be a difficult time of transition. Ussher (1992) states

> For if women are unhappy, depressed or angry after birth, is it accurate to conceive of them as "ill" or to apply a diagnostic category which isolates the woman in her misery, and invariably offers little solace other than that of the ubiquitous biochemical panacea? As well as increasing the fear, the shame, and the feelings of failure in women who experience this supposed illness, they are
reminded that they are clearly failing as mothers. They are not fulfilling the glowing Madonna image with which we are all imbued. So they must be ill. For if we are told that motherhood is the most glorious and creative act in a woman's life, full of joy and radiance, and we experience misery, we must have failed. The reality for many women of tiredness and exasperation, leaving the woman with little sense of an identity of her own, no energy, no feelings of independent sexuality, resulting in a mourning for her lost self, is far from the glowing Madonna stereotype. Are these women ill? (p. 48).

Operating within a medical paradigm is indicative of a cultural bias in our society to view things in terms of sickness with individual pathology as the underlying assumption.

Second, Mauthner (1993) suggests that feminists have also taken exception to the deterministic notion of the etiology of illnesses inherent in the medical model (p. 351). That is, women are not depicted as active participants in their worlds. Mauthner (1993) cites Romito (1989)

Determinism in this context means that mothers are portrayed as passive recipients and "mere containers" in which the battle of intrapsychic conflicts or hormonal adjustments is taking place (p. 352).

This viewpoint does not recognize that there are differences between mothers and that certain events such as a difficult birth or lack of support may have different meanings to different women because of the variations in their individual circumstances.

Third, a feminist perspective would challenge the medical model and suggest that medicalizing women's distress ignores the symptoms of a larger social problem and in turn, does not listen to women's voices about their experience with postpartum depression. Similarly, the current research within the sociological model has not provided an avenue for exploring the subjective experiences of women and suggests only that women may be predisposed to postpartum depression if certain factors are at play. In the case of postpartum depression, women's personal accounts of their experience during this time in their lives are rarely taken into account and are not readily presented in academic literature. Subsequently, the monumental changes associated with motherhood and the societal expectations of motherhood are often ignored.
A fourth criticism of the medical approach to postpartum depression is that within the medical model, the source of the problem and thereby the blame, is located exclusively within the individual mother, or her particular circumstances (Mauthner, 1993, p. 352). Women are seen as physiologically or psychologically damaged. While some of the more current studies suggest the role of social factors in postpartum depression, their analysis still fails to go beyond the individual and address the wider social context of the mothers' experiences.

A feminist view of postpartum depression is very critical of biological and psychological theories as explanations for the development of postpartum depression. The unspoken assumption of these theories is that motherhood is intrinsically satisfying and enjoyed by all women and that any other feelings are abnormal. Jebali (1993) cites Segal (1987).

It is only through feminist theory that women can begin to comprehend their position within society and with knowledge can then acquire the skills generally associated with men: assertiveness, self-confidence, the ability to share their own destiny (p. 60)

Extensive research has searched for the causes of this postpartum crisis; however the dominant contemporary model constructed and maintained by the medical establishment defines this emotional distress as an individual problem. It would appear that because childbirth and childrearing are considered to be a "natural" state for women, any emotional problems related to mothering must then be attributed to a biological or psychological malfunctioning of the individual.

Limitations of Quantitative Research

Nicolson (1986, 1989, 1990) and Mauthner (1993) point our attention to the following paradox. Although depression after childbirth is a woman's health issue, most of the research findings and theoretical perspectives underpinning knowledge of this problem reflect male values. Nicolson (1986) further states that the existing state of knowledge has been accumulated through research designs relying on standardized
measures of "objective" data which mainly deny individual differences in experience (p.135). Nicolson (1986) states

The designs suffer from "overload" by aiming to establish criteria for identification, prediction and treatment of "postnatal depression" as well as to investigate a series of correlations between depression and a range of psychosocial factors. These debates characterize the disparate knowledge base of what may be described as the "psychology" of postnatal depression (p. 36).

Standardized psychiatric measures have been the main source of data collection in numerous longitudinal studies conducted on postpartum depression over the past fifteen years. However, interviewing women who have experienced depression after childbirth has been a neglected aspect of the research on postpartum depression. Such qualitative methods have become increasingly important modes of inquiry for the social sciences as a means by which to collect data that focuses on how certain things happen and how people make sense of their world without utilizing statistical procedures or other means of quantification.

Women who have experienced postpartum depression are the individuals who can best describe their feelings as well as their interpretation and understanding of the experience. Women's accounts of their distress is often not acknowledged or is interpreted as a disturbed or distorted version of reality. Mauthner (1993) states it best

Rather than listen to what the women are saying and feeling and attempt to understand the women's accounts on their own terms, researchers are preoccupied with their own concerns, namely that of discovering what is the "objective truth" about the matter (p.353).

Fortunately, there has been a small but significant shift in the utilization of qualitative methods in research related to postpartum depression. A review of these studies will now be provided.

**Overview of Existing Qualitative Research**

There have been a number of qualitative studies conducted over the past ten years and the majority were conducted during the past five years. Beck (1992) conducted a
phenomenological study that described the essential structure of the lived experience of postpartum depression. She was able to identify a number of different themes including anxiety, obsessive thoughts, self-hatred, and loss of control. Beck critiqued the use of quantitative designs and questioned whether responses elicited by questionnaires adequately assess the lived experience of postpartum depression. She further noted that the two most frequently used depression scales used to detect postpartum depression, the Beck Depression Inventory and the Edinburgh Postnatal Depression Scale did not include most of the themes of postpartum depression that emerged from her study.

In 1993, Beck used grounded theory method to develop a substantive theory of postpartum depression. Use of the constant comparative method revealed a loss of control as the basic social psychological problem. Then, theory triangulation was provided through comparison of the grounded theory study and the phenomenological study. She further identified four stages that identified how women cope with the problem of loss of control; encountering terror, dying of self, struggling to survive and regaining control.

Beck (1995) conducted another phenomenological study that was designed to explore the meaning of nurses' caring for mothers experiencing postpartum depression. She interviewed ten women who had experienced postpartum depression and seven themes emerged from this study that related to nurses caring for mothers experiencing postpartum depression. The women in the study felt that nurses needed to have sufficient knowledge about postpartum depression, needed to provide quick, correct diagnoses, should provide hope to the mothers', readily share their time, make appropriate referrals, provide continuity of care and understand what the mothers are experiencing. The findings from this type of study can make a significant contribution to educating and sensitizing nurses to the issues to consider in caring for mothers experiencing postpartum depression.

McIntosh (1993) completed a longitudinal research study involving semi-structured interviews that sought to identify women's help-seeking behaviours as related
to their perceptions of postpartum depression. The results of this study indicated that the majority of women in the study did not seek help for their depression. He cited two reasons for mothers' reluctance to seek professional help for their depression. First, they saw themselves as suffering from a "normal" reaction to abnormal stresses and second, there was a fear of complaining of such an emotional state because it might lead them to being labeled as mentally ill and regarded as unfit mothers.

The shift towards the use of qualitative methods that recognize women's voices as integral to the building of knowledge is the first step in expanding the existing literature on postpartum depression. The utilization of a feminist perspective in conducting research on depression after childbirth, however, is the missing piece in the creation of a new discourse.

**Creating New Discourse Through Feminist Research**

I find it striking that the existing literature on depression after childbirth has not been researched, to any extent, from a feminist perspective. After all, depression after childbirth is a women's issue. Chernomas and Rainonen (1994) made the following statement

> From a feminist perspective, a mental health problem does not occur simply because the individual is in some way psychologically damaged; its development and expression have been influenced by society's responses to her throughout her life by virtue of her role as a female (p. 3).  

A feminist approach to research includes a theoretical foundation that addresses the social context of women's lives. In other words, a feminist perspective suggests that there is a relationship between the experience of being female and how this oppression affects women's expression of their distress.

Nicolson (1986) advocates for woman-centered research that would present a value-free picture of women. That is, women should be viewed as multidimensional individuals whose psychological and social lives and experiences are as potentially variable as those of men (p. 138). Furthermore, Nicolson (1986) also states that the difference
between feminist methodology and interpretive methods lies in the approach of the researcher to the conceptualization of the problem; relationship with the respondents; and the collection, analysis and dissemination of the data (p. 147). A feminist understanding of postpartum depression recognizes the differences in women's experiences and listens to the feelings associated with those experiences. Women are given permission to use their voices and speak of their suffering and distress. A feminist perspective may contribute to a real understanding of women's lives. Additionally, women's own realities of their experience of postpartum depression could provide much insight into the necessary intervention and treatments needed to assist women in their recovery from depression after childbirth. However, there have been few attempts to examine women's own perceptions about their experience of depression after childbirth and to explore how their perspectives can enrich the existing body of knowledge.

As demonstrated in the literature review in Chapter One, the current empirical studies, review articles and theoretical articles on postpartum depression are diverse and contradictory. This suggests that an alternative approach to social inquiry is needed. However, to date, the alternative approach which would include a feminist analysis and research is lacking. It is important to question why so little qualitative research, and in particular, feminist research, has been conducted in the area of postpartum depression. Is it because such studies do not appear to be highly valued by the majority of research workers publishing in the psychology and psychiatry journals? Brown, Lumley, Small and Astbury (1994) feel that the assumption that women can be believed when they report on their lives is extremely dubious. This was illustrated when the editor of a medical journal rejected their research due to expressed concern that the data depended very much on recall and that no attempt was made to validate the mothers' recall with what actually happened (p. 2). Are women experiencing motherhood distress seen as mentally unbalanced and incapable of rendering valuable information? Are women's words and narratives not recognized as knowledge? We live in a world where women's voices have
been constrained. Women must be seen as reliable informants that are indeed producers of knowledge. New understanding and knowledge about women's experiences with postpartum depression must be developed and it seems only logical that women's interpretations, judgments, evaluations and meanings that they make of their experiences are central to research. It is essential to conduct feminist research that benefits women and places women in the center of vision and at the same time offers a much-needed alternative for improving social workers' understanding of women's mental health needs and the services required to meet those needs.

An alternative feminist model is slowly emerging that is explicitly woman-centered and seeks to find the causes of depression in the structure of society rather than in individual pathology or hormonal imbalance. While the medical model depicts a framework that encompasses both biological and psychological theories to explain the etiology of postpartum depression and simultaneously silences the voices of women, a feminist analysis recognizes that women's accounts of their own experience must be accepted as knowledge.

A number of articles have appeared in journals advocating for a feminist analysis of postpartum depression and recommending the need for feminist research (Rosenberg, 1987; Field, 1989; Mauthner, 1993; Jebali, 1993). Nicolson (1986) carried out research that was concerned with the development of a feminist methodology and a women-centered perspective on women as "new mothers". The intent was to contrast findings and interpretations of data collected from an objective standpoint with one which attempts to examine the way women perceive the world. She interviewed 40 women and provided an opportunity for them discuss their experiences with childbirth and motherhood. Accounts from women depressed three months after delivery suggested that the women evaluated their individual experiences in different ways. The results of her research indicated that many depressed women reacted quite naturally to anxieties and problems surrounding this particular crisis in their lives. That is, women had every right to be
depressed with all of the changes associated with the transition to motherhood. For some of the women, this period of their lives exposed them to an awareness of their oppression as mothers for the first time. Nicolson (1986) felt that the results of her study led to the speculation on the value of qualitative data of this kind for enabling women to explore the nature and cause of their oppression. She also indicated the need for helping professionals to use knowledge about women's perspectives to inform their practice.

Nicolson (1989) conducted longitudinal research whereby she interviewed women at 1, 3, and 6 months postpartum. She wanted to gain a sense of how the women saw their babies fitting into their lives, to ask the women for their definitions of depression and to describe their experiences with respect to those definitions. She concluded that negative feelings or depression are likely to be integral parts of many women's experiences during the first six months after childbirth. She states that her study leads one to suspect that despite the popular view that postnatal depression is an illness, many women do not attribute their feelings to illness and thus lack a means of seeking professional help (p. 130). Nicolson stresses the need to look more closely at the qualitative nature of depression after childbirth and acknowledge the need for psychological counselling on an individual and family level as well as more practical, and at times, essential medical support.

In another study, Nicolson (1990) did further research where she interviewed women and once again encouraged professionals to use a mother's interpretation of her experience of postpartum depression to develop the appropriate type of counselling and support. The results from this longitudinal qualitative study indicated that despite the variations in the women's accounts of their experiences, there are some underlying threads that do link experiences in the postpartum period. First, physical adjustment related to the labour, recovery from the birth, physical exhaustion and breastfeeding were identified as sources of physical discomfort. Second, initial insecurities related to the health of the baby, lack of confidence in dealing with new tasks, the shock of the role change and fear
of not loving the baby were identified by the women in the study as influencing their experience of mothering. Third, the degree and quality of support in the early months of mothering was identified as the single most crucial factor accounting for emotional stability. These supports varied and included the woman's mother, the partner, friends and wider family networks. Finally, a loss of former identity was reflected in the women's stories. This included issues such as loss of occupation, loss of friends, loss of sexuality and so forth. From the data in her study, Nicolson concluded that childbirth and early motherhood fit more easily into a model of loss and bereavement than one of an accumulation of life events, and thus, postpartum depression is actually a grief reaction.

Brown, Lumley, Small and Astbury (1994) wrote a book called Missing Voices: The Experience of Motherhood based on their study of women's experiences of motherhood from pregnancy through the postpartum period. Their position is that women possess crucial knowledge about themselves and that their views have been ignored in much of the existing research. This neglect contributes to an incomplete and distorted picture of what contributes to mothers' emotional well-being on the one hand, and emotional distress on the other (p.8). Women who reported feeling depressed believed that the contributing factors were lack of support, isolation, fatigue and physical ill health. Some of the women did not seek professional help while others sought help from non-professional sources. The women in this study felt that it was important to find someone to talk to about how they were feeling. Brown et al. (1994) felt that the women's accounts of their experience can provide professionals with the necessary information in their practice with new mothers.

Mauthner (1995) explored another little researched aspect of women's experiences with postpartum depression; depressed mothers' social contacts with other mothers of young children. She found that mothers linked their journeys out of depression to the renewal of these relationships (p. 311). Relationships with other mothers were at least as important as the quality of their relationships with male partners. The study supports
Brown et al. (1994)'s findings with respect to the importance of women having someone to talk to about their feelings.

We live in a world where women's voices have been constrained and we need to develop new knowledge about women's experience of postpartum depression. I believe that Nicolson (1986) states this clearly with respect to her own work.

The aim has been to explore the consequences of a shift towards collecting data which explores subjective interpretations of reality, providing perspective on how women see their lives (p. 147).

It is essential to conduct feminist research that benefits women and places women in the center of vision. Feminist research can offer a much-needed alternative for improving not only our understanding of women's mental health needs and the services they require but also for assisting women to recognize the source of the nature and causes of their oppression as imbedded in the existing ideology of motherhood. I would further suggest that in order to accomplish this, the meaning associated with the term "postpartum depression" needs to be challenged and possibly redefined rather than being viewed as a pathological response. I believe that unless this occurs, the health care professionals will use the term postpartum depression to account for women's behaviours without understanding the complexities associated with the role of mothering. Ussher (1992) made the following statement.

The term "postnatal depression" may be a misnomer if it implies that the woman herself is ill, that her unhappiness is caused by an internal dysfunction resulting from childbirth. For is it not the social reality of caring, of mothering, which may be depressing? Men who rear children suffer from depression, as do men and women caring for elderly or sick relatives. Are these groups suffering from an hormonal disorder which merits treatment with estrogen in order to boost their deficient system? Or is it that depression is a normal part of the experience of undervalued, unpaid, isolating caring in a society which values wealth creation and achievement in the public sphere, while ignoring all else? When the reality of motherhood is examined, is it surprising that many women are deeply unhappy? (p. 51).
There are assumptions that motherhood typifies a particular set of prescribed behaviors and any deviations from this represent illness and further assumptions that childbirth constitutes hormonal fluctuations. Every woman's experience will be different and each must be allowed to define the nature of their experiences.

Mothers are the experts and listening to their voices will help to build on the existing body of knowledge about depression after childbirth, help women to better understand their experiences as related to the oppressive nature of motherhood and provide insights for health care professionals about possible preventative interventions. A feminist perspective is an integral component in completing the picture of the experience of postpartum depression. Motherhood must be viewed in a more realistic manner by the medical profession and by society as a whole. Women must get clearance from the traditional ideologies surrounding motherhood. In fact, motherhood is about negotiating these ideologies so that women can be free of the guilt and oppression.
Chapter Three

Emotional Reactions to Motherhood: Towards a New Conceptual Framework

This chapter will examine the feminist literature on motherhood and provide an alternative view of the phenomenon of depression after childbirth. I find it quite interesting that there are two bodies of literature that exist somewhat in isolation to each other; one stream which addresses postpartum depression and the other which encompasses the feminist writings about motherhood and the transition to parenthood. I believe that the ideology of motherhood must be incorporated into any discussion that seeks to provide a comprehensive picture of depression after childbirth. The following chapter seeks to bring these together and presents an alternative way of conceptualizing postpartum depression and its direct relationship with the social construction of motherhood.

While the theories described in Chapter One may be useful in understanding potential causes or predictors of postpartum depression, a more comprehensive theory that incorporates a feminist analysis with a political economy analysis of the ideology of motherhood is required. More recently, an alternative feminist model has emerged that is explicitly woman-centered and looks to find the causes of depression in the structure of society rather than in individual pathology or hormonal imbalances. Women must explore the patriarchal vision of motherhood and seek to deconstruct the myths and expectations associated with the mothering role. In order to accomplish this task, mothering must first be defined and recognized as work. Rosenberg (1987) states that this redefinition is a prerequisite for a feminist analysis of the political economic determinants of mothering as an aspect of social reproduction under capitalism (p. 186). To understand this, we need to look at how motherhood and motherwork are structured in society and how this is related to the evolvement of a more industrialized society.

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A Historical Look at Motherhood

Women have been, historically and in the present, centrally located within the family household. Hudson and Lee (1990) state that, due to economic necessity, women were indispensible partners in the work of household, farm and workshop as well as vital contributors to family incomes (p. 3). The lives of women in pre-industrial societies were affected by where and when they settled. All family members, including children, worked to make family life economically viable. The home was both a place of residence and a place of work. The economic interdependence of family members made family commitment and family obligation strong and although the male/female roles were clearly defined, the work of women was recognized as valuable and necessary to the economic viability of the family. Wilson (1991) describes parenting in a pre-industrial society as the preparing of children for adult life and in most cases this means following in parents' footsteps (p. 14). Children worked very closely with their parents with girls learning domestic skills by working alongside their mothers and with boys learning occupational skills by working alongside their fathers. Fathers were not usually involved in caring for infants; however they were viewed as active and involved parents because they taught their sons the skills of farming. Women were not only responsible for childrearing and domestic responsibilities, but for the day-to-day operation of the farm as well, especially in instances where men earned seasonal income elsewhere through hunting or fishing. However, the work and the status of women were often viewed as social obligations as identified by their domestic and reproductive roles and did not occupy the same status as the occupational identity of men. Nevertheless, while men and women were far from being equal partners, women's contributions to the work of the family were fundamental to the family's survival and thus, valued.

While motherhood has been described as a traditional role, it was not until the latter part of the nineteenth century that changes associated with industrial development...
necessitated that motherhood become a full-time responsibility for women. Wilson (1991) states that The demise of the household economy, the growth of factories and offices, and the increased availability of mass-produced goods for home consumption, which parallels industrialization, changed family responsibilities. Men's entry to the paid-labor force meant families came to depend on their wages. It also meant that domestic work was more exclusively women's responsibility; a responsibility for which they were thought to be naturally suited (p. 13).

This shift to industrialism and a capitalist society created tensions in the male-female relationships. The transition from a rural to a cash-based economy resulted in more families becoming dependent on waged labour as a supplement to farming. Women were encouraged to take their roles as mothers seriously and motherhood became the glue that held the family together during the rapid changes brought about by industrialization (Wilson, 1991, p. 18). Women were viewed as being the reproducers of the workers that were needed for an educated labor force and consequently, they were forced into economic dependence by adhering to society's expectations of women. In this way, the family and particularly, mothering, conformed to the influences of the demands of capitalist growth. At the same time, capitalist development created a hierarchy of workers and since women were excluded from waged labor, a healthy relationship between patriarchy and capitalism emerged. The privatization of home and of motherhood became the dominant feature of industrial societies.

At the beginning of the twentieth century, there were signs that women were beginning to challenge the premise that motherhood should be a lifelong occupation. Women were choosing to remain unmarried, furthering their education, and advocating birth control methods. Economic expansion created job opportunities for women, although these were primarily clerical and sales positions. Some women entered the professional sphere and became employed as teachers, nurses or social workers. Despite the fact that these types of jobs are typically associated with nurturing roles, women began
to realize that there were alternatives to motherhood. This shift, however, was by no means an indication that motherhood was not still imbedded in a set of societal expectations. Despite the transformation of the family's economic role in society, the woman's place was still in the home and motherhood was clearly understood as incompatible with paid employment.

Labour shortages during World War I, while less serious than those during World War II, did create opportunities for women in occupations previously considered unsuitable (Wilson, p. 22). During the depression, economic necessity forced women to take employment although opportunities were restricted because of the fear that employed women would take the jobs away from men. World War II further dictated women's place in the economy; married women came to be regarded as a reserve labour force to be called upon when the supply of male workers did not match the number of job opportunities (Gaffield, p. 32). It must be remembered, however, that women's employment during World War II was only viewed as temporary; men returning home from war still had priority in the workforce. Family allowances were introduced at this time to supplement wages. Since many women had been accustomed to receiving a wage during the war, family allowances were paid directly to women so as to encourage their timely departure from the workforce (Armstrong & Armstrong, 1988, p. 159). At the war's end, women exited the work force and there was a strong desire to see family life return to "normal".

Economic prosperity followed World War II and the values of marriage and family were strongly embraced. The emotional strain of wartime separation of families was an impetus in the resurgence of the family and a woman's responsibility for creating a safe nurturing haven. Women at home, kids in school, men at work and a home in the suburbs were the ideals suggested by the media and by society. Women who did not choose motherhood and childbearing were viewed as unnatural. However, by this time, women
had participated in the workforce and as a result, they soon began to question the message that motherhood was a biological and psychological destiny for all woman.

During the 1980's and the 1990's, major changes have occurred in the economy and once again women are forced into the workplace. The reality is that a dual income is required by families in order to simply make ends meet. The massive and relatively permanent movement of married women into the formal economy has increased women's strength and choices in and out of the market (Armstrong & Armstrong, 1988, p. 163). While there have been many gains such as better access to jobs (although typically associated with lower pay), more equal property rights, and economic self-reliance, these changes still have not improved women's conditions to the extent that equality has been achieved. Specifically, the sharing of domestic responsibilities is an issue that remains a focal point of women's fight for emancipation. Although more women are working outside the home, they also continue to be responsible for the raising of the children and the day-to-day management of the home. However, there is a separation of the household from the economic sphere that has resulted in women assuming the role of nurturer and caretaker of the home. Hamilton (1990) states that the particular nature of the contemporary family as it emerged as part of the developing relations of capitalist society, provided the important preconditions for the women's movement (p.3). The ideology of motherhood and the economic realities of women's lives remains such a contradiction that it certainly is not surprising that feminists have debated and continue to debate the issue of motherhood.

**The Emergence of a Feminist Analysis of Motherhood**

Feminists in the 1960s and early 1970's had a clear objective; equality and greater personal autonomy for women (Everingham, 1994, p. 3). The major obstacle in achieving this goal was seen to be women's role as "mother". As a consequence, the examination of motherhood was an integral part of the feminist movement. The feminist movement attempted to question and challenge the assumption that mothering is a natural activity...
and this questioning continues today. Feminists argued very persuasively that women's sole responsibility for childrearing was at the roots of the sexual division of labor and women's position of subordination.

Armstrong and Armstrong (1988) maintain that the consequences of work and family life not only are different for women and men but also frequently serve to perpetuate the subordination of women (p. 144). Chodorow's, Reproduction of Mothering (1978), took the problems of social reproduction from the societal to the psychological level and constructed a theory that speaks of mothering as a cultural invention as opposed to a biologically given necessity. On the other hand, socialist feminism was primarily concerned with the relationship between patriarchy and capitalism and the reproduction of both class and gender relations (Marshall, 1992, p. 75). During this time, radical feminist writers wrote their critiques of motherhood and called for the overthrow of the nuclear family in favor of a more equalized household. Women's autonomy was a critical factor in feminist thought and that if women were to achieve equality with men, then the role of mothering would have to be reconstructed if not denied altogether.

From a modernist perspective, free-will and autonomy are the ideals espoused in a capitalist society and are the attributes associated with the values that are implicit in a patriarchal society. The industrialization of our society and the inherent shifts towards the values of a capitalist society dictated that the pursuit of wealth was to be emulated and equated with quality of life. Men entered the "public" world or the economy where autonomy and independence were applauded while women's maternity and domesticity were imbedded in the "private" sphere of the home and trivialized and devalued (Rosenberg, 1987; Burt and Code; 1988). Femininity was characterized by domesticity and masculinity by success in the labor market.

During the late 1970s, the ideal of autonomy came under attack by radical feminists who began questioning whether a pursuit of autonomy by women reinforced the
traditional male values associated with possessive individualism at the expense of the 
values of nurturance and connectedness associated with mothering (Everingham, 1994, p. 
3). From this argument then stemmed the premise that attempts to valorize the 
contributions of women as women would simply result in a formulation of women as 
different from men which could result in further exclusion from the workplace and public 
life. Hamilton (1990) states that in the 1990's, there is a shift once again to embrace 
motherhood and attempt to revalue mothering, nurturing and connectedness while also 
developing autonomy, individuality, and the pleasure of diverse accomplishment (p.28). 
This dialectical tension continues to be at the root of women's struggles for equality. In 
addition, Everingham (1994) suggests an alternative rooted in postmodernist thought and 
suggests reworking the notion of "autonomy" to include women's sphere of activity in a 
way which does not essentialize the attributes of women (p. 7). Such a position has the 
possibility of allowing every group of women to speak for themselves and construct their 
own version of emancipation as it may or may not relate to motherhood.

Jebali (1993) argues for a feminist perspective that challenges society's double 
standards where, on the one hand, motherhood is idealized and, on the other, it is 
trivialized and undervalued. It is no wonder that this paradoxical approach may create 
feelings of confusion and inadequacy in the new mother. Because motherhood is 
supposed to be a happy, fulfilling and magical experience, woman will often not voice 
their disappointment and guilt. Many will internalize these feelings and the depression will 
often go unnoticed and untreated.

Hartmann (1993) suggests that feminists must organize a practice which addresses 
both the struggle against patriarchy and the struggle against capitalism. She states:

We must insist that the society we want to create is a society in which recognition 
of interdependence is liberation rather than shame, nurturance is a universal, 
not an oppressive practice, and in which women do not continue to support the 
false as well as the concrete freedom of men (p. 200).
This, however, may be a difficult ideal to achieve in our society because the work
associated with raising children within a family is still considered to be a private, individual
matter. Although the social reproduction of children is an integral and necessary part of
society or the public sphere, this monumental task is assigned primarily to women since it
is assumed to be a natural female role as well as the necessary complement to supporting
and maintaining men's waged labour. Rosenberg (1987) expresses concern that there is a
radical separation of motherwork from social reproduction which can lead to a variety of
consequences including depression, anxiety and violence (p. 182). That is, the daily work
associated with raising children goes unrecognized and it is considered to be a private
matter. She maintains that if it is recognized that the personal is political and that the
political economy is a significant component of even the most seemingly personal of
experiences, then motherwork can be analyzed as an integral part of social reproduction
(p.182). However, given that childbirth and childrearing are considered to be a natural
female condition, depression after childbirth is viewed as an individual problem not
created by or linked to societal structure, pressures and expectations.

It cannot be assumed, however, that the changes in the economic system
associated with capitalism have solely contributed to women's oppression. It can be noted
that it is neither the bearing or rearing of children that is oppressive, rather it is the
institution of motherhood as organized by and for patriarchy in capitalist societies that
makes women into mothers as we know them (Sokoloff, 1984, p. 259). The
responsibilities of women as full-time wives, mothers and homemakers is a unique 20th
century idea for masses of women in our society. The 1950's media image of the happy
housewife portrayed women as devoted housewives and mothers (Wilson, p. 34); the
"superwoman" of the 1990's has had to add the accomplishment of a professional life to
the to the already full picture of housewife/mother. This certainly looks as though it is a
step forward and suggests that a woman can have it all; career, motherhood, or both.
Image, however, has little to do with reality. The reality is that it is women, regardless of
their employment status, and not men who are responsible for the domestic sphere of the home.

The fact remains, however, that sixty-six percent of married women with preschoolers are employed outside the home (Statistics Canada, 1991). Yet, the division between the public and the domestic spheres continues to effectively assign the major responsibility of the work associated with raising children to women without giving them any social recognition or social support. Having children can certainly be a wonderful experience but childrearing occurs within the domain of the home and is ultimately based on male domination. The result is female isolation that may turn motherhood into a burden for women which can subsequently lead to postpartum depression.

The effect of capitalism and patriarchy on the oppression of women cannot be denied. Concurrent to this premise is the fact many myths or beliefs about what constitutes a "good mother" have been socially constructed. Society's inherent ability to continually reinforce these myths constructs an ideology of motherhood that leads to the oppression of women in a patriarchal society driven by capitalist values and this oppression can manifest itself in the form of postpartum depression. At this point, it is now essential to question how socially constructed beliefs about motherhood which are imbedded in the evolution of the political economy can be deconstructed and reconstructed in a manner that values the work associated with mothering.

**The Ideology of Motherhood as Created and Maintained by the Political Economy**

While many different factors have shaped and constructed the ideology of motherhood, the political economy and the values associated with a capitalist society have played an integral part in the construction of a set of myths associated with the institution of motherhood. The political economy within a capitalist society has shaped and created a view of motherhood as a "natural" and "expected" occurrence. Women are seen as reproducers of the labour pool and responsible for the motherwork that women do in the
family and in the home such as providing the nurturing, caretaking and domestic labour (Engels; 1942, 1970; Levine; 1981; Solokoff, 1984; Wilson, 1991). Men, on the other hand, enter the public sphere where their activity is recompensed through higher waged labour. Thurer (1994) believes that the development of capitalism led to this division of the workplace and the home (p. 134). Over the years, women have been pulled in and out of the public work force as the economy required and were at the same time expected to support men and their pursuit of independence, autonomy and self-fulfillment.

A modernist point of view embraces the notion that motherhood is a biological human necessity, hence all women are expected and required to sustain the species. Accepting this premise would negate that there is a choice and that the subjective experience of women as mothers is irrelevant. Levine (1981) states that women are denied what men take for granted (p. 48). This is further complicated by the fact that mothers are expected to be self-sacrificing; therefore her needs as a person and her role as a mother are not a source of conflict. Women, in fact, do have the right to a separate and distinct existence outside of motherhood.

Concurrent to this premise is the fact that each woman has the task of developing her own definition of motherhood. Guscott and Steiner (1991) discuss a developmental model that views parenting as a developmental stage with specific tasks. This view adopts the premise that a woman's sense of self is challenged as she attempts to integrate her new role and identity with her previous relationships and identities.

This task, however, may prove to be extremely difficult in a patriarchal society where women are constantly struggling to identify their roles since these roles have been constructed and dictated by society. Knight (1992) states that postpartum depression is a clear response to oppression and is not about personal inadequacy (p. iv) and women must explore the patriarchal institution of motherhood to identify the origins of the oppression. Jack (1991) describes the need to deconstruct the patriarchal institution of motherhood, specifically its internal oppressors, myths and prescriptions. Knight (1992) identified
theses myths and prescriptions as: myths of woman's nature, myths of mothering and homemaking, myths of fathering, myths of children, and myths of childcare experts.

Some of the myths of woman's nature include beliefs that raising children is instinctual, bonding with a child is instantaneous, caring for children and a home is fulfilling and that mothers are the best caretakers for their children. Again, women's biological capabilities are at the root of these assumptions and are reinforced and expected by society and fathers themselves. Many women choose to return to work after a maternity leave and find that employment is more satisfying and challenging than full-time motherhood. The conflicting messages from society about such a choice place women in a position whereby they are torn by "what is the right thing to do". The concept of maternal deprivation or bonding theories have been instrumental in holding mothers responsible for any problems associated with a child's development. There is a belief that proper attachment between mother and child occurs shortly after the birth of the child and should this not occur, the effects will be disastrous on the mother-child relationship. In effect, the responsibility falls on mothers to ensure "the normal development" of a well-adjusted individual and in this scenario, mothering requires that a woman be present with her child twenty-four hours each day and be continually and actively engaged, providing stimulating and attentive company (Marshall, 1991, p.83).

Myths of mothering and homemaking propose that because mothering is instinctual, it is not considered work. Motherhood as described by Bernard (1974, p. 12) consists of two major components. One is mothering and concentrates on the mother-child relationship and the necessary activities that enhance the emotional and physical well-being of the child. The second component is the extra housework associated with maintaining a home such as shopping, laundry and cleaning. Bernard was one of the first feminist critics to call for a balance between work and family within women's lives and for shared parenting as a way of moving beyond stereotypical views of motherhood. Helen Levine (1981) states that motherwork usually becomes visible to men only when it
malfunctions or when it is no longer available as a service to them and their attachment to the labour force (p. 12). The concept of work is socially constructed in our society and it is assumed that this reference is to paid wages for employment outside the home. The motherwork done in the home, however, remains unrecognized and unrewarded. A dialectical tension is established for the mother that must be recognized such that women are supported in their efforts to attain equilibrium.

**Myths of fathering** focus on the premise that fathers see themselves as helpers rather than as necessary partners and consequently, they consider themselves less important than mothers in the raising of their children. It may be argued that this is not really a myth because men and women are socialized into these roles; however that fact remains that men are given the message that they are not as capable as women with regards to raising children. It could also be argued that if men were provided with the opportunity to participate fully in the raising of their children, they could handle the role and responsibility as effectively as women. It may be far more useful to use the term "parenting" as opposed to making a distinction between fathering and mothering.

**Myths of children** suggest to women that mothering is a fun, easy and very fulfilling experience. These myths lead us to believe that we can expect to have a child that is healthy and vibrant and this will fulfill our existence and enhance our relationship with our partner. When a child challenges this set of expectations, a mother's character, status and identity will come into question by herself and society.

**Myths of the childcare expert** indicate that although mothering is supposed to be instinctual, it is also necessary to obtain information from experts in order to successfully parent. Books, magazines and parenting courses offer realms of ideas and suggestions to help mothers do their job more effectively. There is a contradiction created which places women in a quandary because on the one hand, they are expected to know how to parent, and on the other, they should listen to the experts.
Exploring the underlying assumptions and expectations in these myths may well show that they serve as contributing factors to the experience of depression in mothers for they can be seen as limiting, controlling, confusing and oppressive. Many women do find fulfillment, joy and a sense of satisfaction during parts of their work as mothers; however, guilt and anxiety associated with the inability to be the "perfect" mother can be an overwhelming and isolating experience.

The inherent belief in all of these myths is that the work associated with motherhood is not "true work." For many women, becoming a parent is devastating and confusing because this type of work is so unfamiliar. Furthermore, while expectant parents participate in childbirth classes and read books, they are not prepared for the reality of the tasks of parenting. Children do not arrive with an instruction manual. There is an assumption by society and the woman herself that she will know exactly what to do and be able to anticipate the child's every need. Parenting is an important and difficult task with an extensive job description. Childrearing, like any other job, must be learned. However, the job of parenting occurs in the privacy of the home which enables it to continue to go unrecognized as work. Often when a woman speaks of the difficulties associated with parenting, she is quickly admonished with comments such as. "you were the one who wanted this baby" or "you should know what to do."

Lack of recognition of mothering as work can contribute to an array of feelings for new mothers. As one new mother who suffered from postpartum depression described her experience

I have been working since I was sixteen years old. I've always felt as though I was really contributing to society. All of a sudden, I am a mother and I am constantly trying to justify my time at home with my baby. I feel as though I need to keep doing things whether it be six loads of laundry or cleaning my house from top to bottom so that I am not viewed as lazy and unproductive because I am at home with my child (Parent, 1995).
Women continue to be on the horns of a dilemma. Whether they choose to return to employment outside the home or to remain at home with their child, society has developed viewpoints that cast the woman in a disadvantaged light. Women are criticized if they choose to give up the "natural" task of mothering to return to the workplace and in addition, the problem is further compounded since they are expected to perform both roles simultaneously. In contrast, mothers who choose to remain at home face similar categorization in that they are expected to both perform the task of mothering in such a way as to provide sufficient free time to pursue economic gains for the family. Only in those situations where a mother is able to assume the role of "superwoman" is the societal pressure to be both mother and worker met. However, this task is accomplished at the expense of women's quality of life and emotional health.

Furthermore, the political economy is organized in such a way that the ideal of motherhood as depicted in media is unattainable. The barriers of home are infiltrated with messages of the perfect mother in magazine advertisements and parenting manuals depicting perfect babies, well-behaved children and slim, well-groomed mothers. In this scenario, women will be breastfeeding and playing with the older child while also studying for a law degree. Imagine the emotional state of a woman who is holding a dirty-diapered, screaming child while surveying the battleground that is her home. Further imagine the energy required to face all of this on only four hours of sleep. To aspire to the engineered and false utopia is to scream for abject failure.

Society and the political economy further devalue motherhood by the lack of recognition and structuring of a postpartum period. Many cultures have provided very rich systems of social support to new parents; however, postpartum customs and rituals seem to be foreign to the Western eye. The industrial capitalist societies are focused on delivering healthy babies with the aid of the most modern technologies. In addition, the medical profession strives to maximize efficiency, hence revenue potential, by developing procedures that permit the medically safe discharge of new mothers and their child from
the hospital in two to three days. Rosenberg (1987) maintains that once again women receive the message that unwaged caregiving in the household is not recognized as either a contribution to societal reproduction or as real work but rather it is seen in essentialist biological terms for women and as a private and personal reward for waged work for men (p. 188).

The feelings associated with postpartum depression range from anxiety to fear. In some cases that fear and anxiety may be alleviated by direct knowledge that the emotions being experienced are part of the idealization of motherhood. In practical terms, women must possess the knowledge that being an "ideal parent" is not required and in fact, the depression being experienced is not at all unnatural. A feminist point of view is essential in that it may "empower" women to question and challenge the socially constructed expectations and myths associated with parenting and that very empowerment may be therapeutic in itself. Unfortunately, changing societal beliefs and values is another matter.

To provide a more comprehensive understanding of postpartum depression, I believe that the theory just described more accurately depicts women's experiences as mothers because it encompasses the societal structures that have been both historically and presently created, shaped and used to maintain the ideology of motherhood. Wearing (1984) expressed it well in her statement that there needs to be a theoretical framework which challenges rather than accepts women's "natural" propensity for rearing the children she bears and for performing household tasks (p.10). The mother's inability to attain societal ideals and expectations could certainly place her emotional health at risk which in turn could lead to depression after childbirth.

Although the literature is slowly beginning to provide a more comprehensive picture of the phenomenon of postpartum depression, there clearly is a division between the medical-psychiatric, sociological and feminist perspectives. One of the major aims of my study, therefore, is to bridge the existing gaps in the literature pertaining to postpartum depression and motherhood. Additionally, this study seeks to learn more
about the experience of postpartum depression as described by the women themselves. In order to achieve this goal, my central research question is as follows: "What can be learned from listening to women's voices about their experiences with depression after childbirth?" My study is designed to be a vehicle through which women's previously silenced voices can come forward and create new knowledge for society about the devastating reality of depression after childbirth.
This chapter presents the research design for my study which explores women's experiences with postpartum depression. While quantitative and qualitative methods can be used in feminist research, qualitative methods have been particularly useful in feminist inquiry (Cancian, 1992; Shields & Dervin, 1993; Chernomas & Rainonen, 1994). Given that the aim of my study was to explore the women's experiences with depression after childbirth, an exploratory qualitative study utilizing the principles of feminist research was deemed to be the most appropriate. Additionally, as there has been limited qualitative work done in my chosen area of study, this further informed my rationale for a study of this nature.

However, before proceeding with a description of my research design for this study, I believe that it is essential for me to discuss two areas that are integral to the design of the project. First, I will discuss my understanding of feminist research and its application to my research design. Second, since it is essential to produce an analysis which goes beyond my experience as a researcher, it is important to clearly define the positioning or perspectives that I brought to the research process.

### Defining Feminist Research

Feminist research has, at its core, a commitment to describe, explain and predict phenomena within the context of women's oppression (Chernomas & Rainonen, 1994). Although feminist research is founded upon diverse theoretical perspectives, there are some common epistemological and methodological characteristics of the feminist approach to research. Epistemology refers to assumptions about the nature of knowledge and truth, including assumptions about how truth is discerned, how knowledge is acquired and what the relationship is or should be between knowing and being (Faver, 1994; Stanely and Wise, 1992). Methodology, however, is a perspective or an approach which
may or may not specify its own particular research methods or techniques (Stanley and Wise, 1992; Cancian 1992). Epistemology, in turn, can be viewed as the foundation for methodology and method.

With respect to common epistemological underpinnings of feminist theory, it is recognized that women can be knowers and their experience is a legitimate source of knowledge (Stanley and Wise, 1990; Cancian, 1992; Swigonski, 1994; Wuest, 1995). In other words, women are the experts about their experience and that subjective experience is credible data. Another commonality of feminist epistemology is the contextual and relational nature of knowledge; one that discovers social process within social structure (Cancian, 1992, Riger, 1992, Shields and Dervin, 1994; Wuest, 1995). Finally, there is the issue of intersubjectivity. Intersubjectivity can best be understood as the reciprocal sharing of knowledge and experience between the researcher and the researched such that knowledge development occurs through a dialectical and collaborative relationship (Oakley, 1981; Duelli Klein, 1983; Sheilds and Dervin, 1993).

While there seems to be a general agreement that a need for feminist research exists, an ongoing debate exists within feminist writing as to whether or not a distinctive methodology exists (Harding, 1989; Devault, 1990; Reinharz, 1992; Riger, 1992; Cancian, 1992). My purpose for addressing this issue is not to take a position, but rather to suggest that there may be some common values which constitute a feminist method. Feminist methodology does not prescribe a single model or formula but rather provides distinct ways of extending the methods of existing qualitative tradition. The methodology for this research study made every attempt to remain consistent with feminist research principles. Cancian (1992) cites the work of Cook and Fonow (1986) which identified five elements of feminist methodology, based on a survey of the previous decade of feminist sociology. These include the need to focus on gender and equality, the use of qualitative methods, doing research that is for women, critiquing research and employing participatory methods. Wuest (1992) identifies three principles that underlay feminist
research; knowledge produced by the research should be useful for the participants, the research method should not be oppressive and the research method should be reflexive allowing for reflection on both the intellectual tradition and the progress of the study (p. 129). One final methodological issue that must be considered is that the research should have an emancipatory component to it. An emancipatory social science should provide women with the necessary information that will help them see more clearly their position in the social world. (Acker et al., 1983; Shields and Dervin, 1993; Chernomas and Rainonen; 1994). Other feminist scholars have discussed and elaborated on these four principles (Stanley & Wise, 1990; Fonow & Cook, 1991; Reinharz, 1992; Cancian, 1992; Riger; 1992).

Allan (1994) states that feminist inquiry, in rejecting the positivist assumptions of objectivity and value-free methods, considers the researcher's point of view to be an integral part of the data (p. 530). At the same time, the issue of reflexivity must be taken into consideration. This refers to researcher bias influencing research questions and analysis and the need for the researcher to be aware of her biases and background and be able to situate that information in relation to the experience of the researched (Shields and Dervin, 1993; Allan; 1994). This view needs to be made explicit and in the reporting of my research I acknowledge and own as mine the many preconceptions and prior interpretations I brought to the research process. My personal experience as a mother who has explored her own struggles with motherhood was an integral piece of this study. My professional experience as a family counselor and parent educator has also influenced my beliefs about motherhood and postpartum depression. Thus, I initiated this study with the goal of critically examining the existing ideology of motherhood and its relationship to women's emotional health. At the same time, I also recognized the importance of listening to women's stories and their own interpretations of their experience to see how their perspectives could inform my own beliefs. In other words, my own receptivity to learn rather than to prove or validate my own biases was integral to the research process. By
incorporating the similarities, the differences, and the shared experiences between myself and the women in the study, we created a liberating piece of work that will benefit all women.

The research design for my study utilizes a feminist conceptual framework that makes every attempt to adhere to the common epistemological and methodological characteristics of the feminist approach to research as discussed. Since women in the study benefit from the consequences of this research, then the research may be considered feminist. Consistent with feminist inquiry, in-depth interviewing techniques were utilized and the meanings and interpretations of the data emerged from a process of mutual interaction between the participants and myself; together we attempted to understand and construct the participants' realities. The design was constantly evolving as a result of the existence of multiple realities and the interactive relationship among the participants, myself and the context. The ultimate goal of this study was to recognize women's voices, listen to their experiences and utilize their knowledge as a means to strengthen and challenge "objective" scientific standards.

Sample

I obtained my sample of women with the help of the staff from the Pacific Post Partum Support Society in Vancouver. This agency provides the services of telephone counselling and support groups to women experiencing postpartum depression. I felt that choosing this particular agency from which to identify appropriate participants would provide the greatest potential for a sample that would yield rich and informative data.

In developing my inclusion/exclusion criteria with respect to potential respondents, part of the decision-making process was whether to interview women who were presently experiencing postpartum depression or women who had participated in the support groups and had recovered from postpartum depression. This was resolved through initial discussions with the agency which set parameters in relation to the choice of population. The staff of the agency expressed concerns about confidentiality issues for women
presently attending the support groups. The staff did agree to assist me with contacting women who had completed the support groups. Subsequently, I realized that this choice of participants was also more aligned with the research question which asked what could be learned from listening to women's accounts of their experience with postpartum depression. In order for women to provide such information, it was more appropriate that they be at a place in their recovery where they are able to recount and evaluate their experience.

I recognized that there may be limitations in retrospective research in that as time passes people may often forget, minimize or change their perceptions of their actual experiences yet at the same time the meanings that women give their actual experiences can provide valuable and rich data. Brown et al. (1994) cited research that shows that women do not suffer from memory distortion and in fact, were able to remember and describe their feelings of depression three years after the event. In light of this viewpoint, I made a decision to interview women who were up to three years post-recovery.

The sample of eight was obtained through two recruiting processes. The first step involved submitting a brief proposal (Appendix A) outlining the major components of my intended study to the staff and the board of directors of the agency, upon which I was then granted approval through a letter (Appendix B). The first stage of recruiting began when I requested and received preliminary approval from the Ethics Committee at the University of British Columbia to advertise for participants in the agency newsletter that was being distributed prior to submission of my completed research proposal. I designed an advertisement (Appendix C) for the newsletter asking for women to contact me by telephone if they were interested in participating in the study. I obtained five participants through this process. After receiving full approval for my research proposal, I began the second stage of the recruitment process. This method of third party recruitment was utilized whereby the staff from the agency identified women who had graduated from their support groups and who they felt would be able to provide me with information-rich data.
Letters which outlined the purpose of the research were written by the staff (Appendix D) and myself and both letters (Appendix E) were sent to the women. They were informed to contact me directly if they were interested in participating in the study. This recruitment procedure ensured that confidentiality on the part of the participant would be maintained as the agency had no means of knowing which of their previous clients chose to become involved in my study. A further six women contacted me through this method of recruitment. All of the women fit the criteria; therefore, I chose the participants in the order that they contacted me. Although I would have liked to interview all eleven women, existing time constraints associated with conducting two interviews prevented me from doing so. The other three women did consent to remaining on my list of potential participants in case I decided to increase the size of my sample at a later date.

**Data Collection**

**Measure**

An interview guide (Appendix G) was utilized and it is important to stress that an interview guide is exactly what its name suggests, a guide. The purpose of the guide was to provide a framework that allowed for a range of perspectives to emerge and at the same time allow for flexibility in the interview process. The questions were developed with the research question in mind: what can be learned from listening to women's voices about their experience with depression after childbirth? Participants were not provided with the interview guide in advance as I wanted the interviews to remain as spontaneous as possible.

Grams (1995) suggests that the questions be organized in a way that seems logical, beginning with the most abstract. My first question was open-ended in that it simply asked women to tell me about their experience with depression after childbirth. This allowed the women to tell me their story first and reduced the likelihood that my questions would bias them or take them away from their story. I quickly discovered that the women
had their stories to tell me and the interview questions truly became only a guide. In many cases, it was not necessary for me to use the questions from the guide because the women were already addressing the issues that the questions were designed to explore. This in turn added to the credibility of my questions by reinforcing the appropriateness of their content. As a further means of enhancing soundness and credibility, the questions for the interview guide were developed through consultation with my research advisor, staff from Pacific Postpartum Society, and a therapist in private practice who conducted research on postpartum depression for her Master's degree. In addition, a qualitative study by Small et al. (1994) utilized a set of questions that I adapted for use in this project. The interviews flowed smoothly and this contributed to the credibility and soundness of the means by which the data was collected.

**Interview Procedure**

In order to accurately reflect women's experiences with depression after childbirth, semi-structured multiple interviews employing open-ended questions were utilized. This type of method provided me with the opportunity to hear the ideas, thoughts and feelings as expressed by the women themselves. Chernomas and Rainonen (1994) state that systematic recording of women's descriptions of their experiences is best achieved through multiple in-depth interviews, with smaller samples, conducted over time, and including a variety of open-ended and focused questions. I chose to conduct two interviews with each woman for a number of reasons. First, I felt that two interviews would help to establish a strong interviewer-interviewee relationship. Second, in addition to building trust, two interviews would provide me with an opportunity to share the transcripts and invite the participants' viewpoints and analysis. Finally, more in-depth information would be obtained because of the opportunity to ask more questions or to seek clarification on certain issues. These considerations also served to enhance the credibility of this study.

Once I obtained approval from the UBC Ethics Committee (Appendix I), I contacted the women to schedule the interviews. I made every attempt to accommodate
the women's circumstances with respect to the scheduling of the interviews. Seven out of eight interviews were conducted in the women's homes. In some situations, we had infants with us and our interviews were often interspersed with diaper changes and breastfeeding. I did not feel that this was a limitation to the research process.

Alternatively, I felt that I was provided with a wonderful opportunity to see women in the context of their own homes and the everyday realities of motherhood. In all cases I was welcomed into their homes as a guest and not merely as a researcher. Finch (1984) states that interviewing women in their own homes can contribute to a relaxed discussion of some very private material. I certainly felt that this was the case. One woman felt that she would rather go somewhere to talk because her home did not have an appropriate space that would provide privacy. We were able to utilize the office space of the Pacific Post Support Society. She was very comfortable with this choice because she had previously attended a support group at this facility and had fond memories of the warmth and safety of the room.

Prior to the interviewing process, I had given consideration to the issue of establishing rapport in the interviewing relationship. From a feminist perspective, there are certain characteristics associated with the interviewing process that can reduce the exploitative potential in the interview and enhance a level of trust and comfort (Finch, 1984; Ribbens, 1989; Devault, 1990). In particular, Finch (1984) speaks to the issue of "unmasking" whereby she encourages the researcher to disclose crucial pieces of personal information that may service to enhance the level of comfort in the interviewer-interviewee relationship. I anticipated that the women in this study would want to know whether I had experienced a postpartum depression and, if not, they would want to know my reasons for conducting this study. Therefore, I made a decision to provide the women with information with respect to both my personal and professional interest in the area of depression after childbirth. In addition, as discussed earlier, while it is essential that the researcher acknowledge her own biases about the topic under study, I also felt that it was
important to be honest and candid with the women about my own biases about postpartum depression.

I stressed to each woman that I was an independent researcher and they were not obliged to answer any questions that they are not comfortable with. We further discussed the issue of confidentiality and the importance that they clearly understand their names will not appear in the transcripts, that all audiotapes would be kept in safe-keeping and the transcripts will be viewed only by myself, my advisor and possibly someone I may hire to do the transcribing.

All participants agreed to the audio recording of the interviews. Consistency in data collection was ensured by recording the entire interview. This enhanced the credibility and soundness of the data collected. After the introductions, consent forms were signed (Appendix F). Women were encouraged to tell their story in their own language and style. This served to shift the bulk of the control into the hands of the participants thereby decreasing their anxiety level and enhancing their sense of safety in the interview process. The women appeared relaxed and open in sharing their stories with me. Participants were given as much time as they needed to consider and answer all of the questions they were asked which accounted for the varying lengths of interview time. The first interviews lasted between one to one and a half hours. During this phase of the interview, process notes were taken as a means of ensuring thorough documentation of both the participants' responses in addition to my own thoughts about the interview. I also found that the information provided in the first interview often provided new directions for discussion in the second interview.

Prior to the interview process, I recognized the fact that women's accounts of depression after childbirth may elicit some strong feelings and emotions and it would be important for me to be sensitive to that fact. One of the ways I minimized the effects of this process was to provide women with an opportunity to talk about their experience with the interview. Immediately after the first interview, I allowed for a debriefing
whereby we discussed the interview process, the quality of the participant-researcher interaction and any strong reactions they may be having to the re-telling of their stories. Within two days after completing the initial interview, I re-contacted each woman to inquire how she was feeling with respect to the emotional climate of the discussion and to ensure that she had a support person with whom she could talk with about any strong feelings she may be having. I also took into consideration that I may be faced with a dilemma whereby some women may look to me for answers and support. Oakley (1981) and Reinharz (1992) suggest that answering women's questions that have been triggered during the interview process may prove to be useful in that the researcher may find that answering participants' questions enhances further sharing on their part. I took into consideration that it was important for me to be able to differentiate between "researcher" and "therapist" and while feminist methods do advocate for intimacy, openness and the development of a close relationship, I strived to maintain a balance. Honesty, empathy and appropriate acknowledgment of feelings were essential components that I employed to provide a safe and trusting relationship between myself and the women in this study.

One aspect of the interviewing process that I did not anticipate but I do feel is worth mentioning is the strong emotional reactions I had to the intimate stories that were shared with me. I found that I was very moved by the stories of these women and I had not previously established any formal means of debriefing for myself as a researcher. I would suggest that this be taken into consideration by researchers who are involved in interviews that involve the re-telling of emotional experiences.

At this point, I then personally transcribed all interviews and provided each women with her transcript. I personally delivered the transcripts and I acknowledged the fact that they may find it difficult to read their own words and that strong feelings could arise. I encouraged them to find someone that could be supportive to them through the process. The second interviews were held within a month after the women had received the transcripts. The second interviews lasted between forty-five minutes to an hour and a
half. I discovered that some women had examined their transcripts very closely while others chose not to read them. Of the women who read their transcripts, many spoke of it as very helpful in that it allowed them to see things more clearly. One woman described it as "having a mirror in front of her" and likened it to a "purging" that allowed her to process it in a different way other than "in her head." Those women who chose not to read the transcripts described it as a "daunting task" that elicited mixed emotions.

Data Analysis

The constant comparative method of analysis (Strauss & Corbin, 1990) was utilized to analyze transcripts and identify categories and themes. To ensure the confidentiality of the participants, all information identifying individuals was stripped from the transcripts and the recordings were kept in a safe place accessible only to myself. Upon completion of the study, the tape recordings were erased or given to the women at their request.

The analysis began with the transcribing of the completed interviews. There are systematic techniques and clear procedures of analysis that occurs through a continuous interplay between analysis and data collection. I began collecting, coding and analyzing the data from the beginning of the study. The method can actually be viewed as circular because it allowed me to change focus and pursue ideas and leads that were revealed by the ongoing data analysis. My own creativity was an integral part of this analytic process. It was actually this creativity that enabled me to ask questions of the data, to re-formulate those questions as hypotheses began to emerge and to develop interpretations of the data that explored the richness and diversity of human experience.

As stated above, the processes of data collection, coding and analysis occurred simultaneously. In relation to my own work, the data was collected through two in-depth interviews and field notes. All ideas generated during the process of coding and comparing categories were put into theoretical memos. Theoretical memos were used as means of maintaining the emerging hypotheses and hunches with respect to the interplay
of the data. The purpose of this process was to trace my line of thinking with respect to the analysis of the data which in turn added to the credibility and soundness of the research study.

The interviews were transcribed and a margin was left on the right hand side of the paper where coding and memoing occurred. I used a system of open coding; approximately ten pages of transcript were initially examined line by line in hopes of identifying the processes in the data or in other words, conceptualizing the data. Strauss and Corbin (1990) refer to this as the taking apart of an observation, a sentence, a paragraph and giving each incident, idea, or event a name or something that stands for or represents a phenomenon. Basically, this meant that I attempted to identify every single idea represented in each and every line and each new idea was given a code name. I will qualify this statement, however, with a corollary in that I found that coding line by line did not seem to have a "comfortable fit" with the words of the women participants in my study and I began to look at the data in terms of distinct thoughts and observations as was reflected in their accounts of their experience. All significant statements were highlighted with a coloured pencil in the transcript. Then, each code was compared with other codes so that similar phenomena were given the same name. In this first-level open coding, I organized the information into provisional codes and I attempted to use the words used by the participants.

Once the numerous codes or concepts were developed, I began to group these concepts from more to less abstract. This process was accomplished in two ways. First, I formed three columns and put the codes into the columns from less to more abstract. The most abstract codes were the categories, the codes in the middle column became the properties or dimensions and the third column codes were referred to as the circumstances or conditions of the properties. This method was employed for each individual interview, the only difference being that the coding process became much easier as a result of practice. I was extremely careful not to force the data from the remaining transcripts into
the initial framework, but rather went through the rigorous process of determining how
the codes from the subsequent transcripts fit within my existing framework. Additionally,
I constantly compared the framework with the data itself, cognizant of the fact that the
language of the participants' must be reflected. In making sure that the language
represented in the framework was meaningful, the credibility of the data analysis was
further enhanced.

In an attempt to verify the findings, I utilized a second method whereby I
photocopied the transcripts in different colours of paper and after identifying significant
statements, I cut out the quotes and then grouped them according to similarity and
likeness. Interestingly enough, I discovered that the findings of the two methods
corresponded to one another and in fact, there were some new additions to the conceptual
framework. This method proved to be extremely useful when it came time to illustrate my
findings with specific quotes. In essence, these were two different ways of approaching
the data that enhanced and reinforced one another in terms of the development of the
conceptual framework thus adding credibility to the study.

Oakley (1981) advocates for generating an approach to the research which
engages both the interviewer and respondent in a joint enterprise (p.44). This also
addressed the issue of developing a non-hierarchical relationship between myself and the
women in this study. I sought to achieve this goal while simultaneously enhancing the
credibility of the study by providing an opportunity for the women to be involved in some
aspects of the analysis of the data. During the second interview with the women, I
presented the preliminary findings of the working model to them for discussion.
Consistent with feminist methods, this process enabled me to enhance credibility by
seeking participants' reactions to, elaboration of and corroboration of emergent categories
and themes that constituted the development of the working model. Credibility and
soundness of the study was also enhanced through verification that this model was
representative of their individual experiences. All of the women were appreciative of the
opportunity to participate in this aspect of the analysis and provided me with constructive feedback. All eight women responded favourably to the model.

I did not transcribe the second interviews for two reasons. First, the time constraints prevented this from occurring. Secondly, the purpose of the second interview was to provide an opportunity for the women to discuss their transcripts and for me to present the framework I had developed, therefore, the content of the tapes was highly conversational. I chose to listen to the tapes, keep notes and record any verbatim quotes that I felt were significant and meaningful.

The procedure of data analysis was a process of constant comparisons and of continual revisions and modifications. The findings of this analysis were supported with verbatim quotes to add to the credibility and soundness of the findings. The process of reducing the data into a manageable visual model (Appendix I) that was representative of the women in this study was an end goal of this research design. Although the findings of this study may reflect that of other women who have recovered from postpartum depression, the purpose of these interviews was to understand the experiences of these eight women as they reflected back on their experiences with postpartum depression. The aim of my study was not to generalize the findings of the research, but rather the aim was to add insight and promote new understandings of the phenomena of postpartum depression.

Criteria of Soundness

All research must respond to canons that stand as criteria against which the trustworthiness of the project can be evaluated (Marshall & Rossman, 1995, p. 143). While many of these issues have been addressed in the research design I would like to summarize the trustworthiness of my study with respect to the four criteria identified by Lincoln and Guba (1985). These criteria include credibility, transferability, dependability and confirmability.
The credibility of this study was enhanced through prolonged engagement which enabled me to understand the context of the participants, to minimize distortions and to build trust. Also, peer debriefing was utilized throughout the process to challenge, question and clarify my own biases and interpretations. Finally, member checks were implemented whereby data, analytic categories, interpretation and the development of a visual model were discussed with the participants to ensure that there was adequate representation of their own realities.

Transferability refers to how transferable and applicable these findings are to another setting or another group of people. With respect to my own study, I have provided a thick description of the design that shows how the data collection and analysis was conducted. In addition, the thick description supported by verbatim quotes provided in the results served to create a contextual picture which captured the meanings of the women in this study.

Dependability refers to whether the findings could be replicated if the study were conducted with the same participants in the same context. I attempted to account for the process of the inquiry through a detailed description with respect to the design of this project. All decisions and the reasons for those decisions and any subsequent changes were provided.

Finally, confirmability is described by Lincoln and Guba (1985) as the need to ask whether the findings are reflective of the participants and the inquiry itself rather than a creation of the researcher's biases or prejudices. In other words, while dependability refers to the process, confirmability refers to the product. As stated earlier, the natural subjectivity of the researcher will shape the research and I feel that I have adequately built in strategies for balancing bias in interpretation. In this study, an extensive audit of the data collection and analytic process were maintained in the form of theoretical memos, a reflexive journal and process notes. By looking at the data, the findings, the interpretations and the recommendations, I feel that these areas are clearly supported by
and grounded in the data or the words of the women in the study. I believe that the time,
thought and energy expended in developing a sound rationale for this study and the
subsequent conducting of this study has contributed to a theoretically sound and
methodologically efficient research project.
Chapter Five

Results: Revealing the Unheard Voices

In order to remain congruent with the feminist principle of "listening to women's voices as a means of developing knowledge", this chapter will present the findings of this study as reflected by the verbal accounts of the women themselves in their process of remembering their experiences with depression after childbirth. There are certainly no words more powerful than those expressed by the women themselves. Thus, this chapter also seeks to honour, validate and represent their voices so that they may be heard, acknowledged and ultimately, understood. Upon analysis of the data, it became apparent that as the women looked back on their experience, three stages or categories evolved in terms of how they made sense of that time in their lives. "Why Did This Happen?" represented the first part of the story whereby women attempted to understand or determine why they experienced postpartum depression. "Spiralling Downward", the second stage, focused on what it was like for them as the postpartum depression entered their lives and enveloped them in darkness. The third stage, "Getting to the Other Side", addressed the process of their own recovery. These stages, together with their respective properties and elements serve to make up the working model represented in Appendix H.

The time that I spent listening to these women's accounts of their experiences with depression after childbirth not only provided me with a greater understanding of their tremendous ordeals but also enlightened and challenged my own perspectives with respect to this phenomenon called postpartum depression. In addition, the development of the emerging theory not only provides a contextual picture of the experiences of the women involved in this study but serves to enhance, support and challenge the existing literature on postpartum depression. Subsequently, the knowledge developed from women's accounts of their experience provides implications for practice, policy and further research, all of which will be discussed in the final chapter of this paper.
Before delving into the findings of this study, I feel that in order to create a picture that depicts the despair and distress of the women who have experienced postpartum depression it would be helpful to look at what they had to say about this difficult time in their lives. When I asked the women to tell me about their experience with postpartum depression, the following statements vividly described some of their accounts:

My experience. It was a nightmare. It was a real nightmare. I remember... when you look back on it, it was scary. It was unbelievable. I couldn't believe it was happening to me and um, I couldn't believe that there was no way to get a miracle pill to get over it. I don't think I've ever seen anyone who was depressed before or I didn't think or know anyone with anything mentally wrong with them. It was completely beyond the realm of my understanding so I was totally shocked by what I was feeling, the things I was doing. Unbelievable. (#6, p. 1)

When I was a young girl or a young woman, I could never imagine I would go through this experience. I went through a tremendous amount of thinking throughout the last year and this year. Well, with the first baby, I thought it was something...I hadn't cleared the whole thing in my mind. I thought, it was like...well it was something and it went away. Now I know that it was a serious matter. (#3, p. 1)

The whole thing of helplessness and hopelessness. Reading the articles on depression and it was like, "oh, yeah, I know what that blackness is. I know that. (#4, p. 21)

So I think it is one of those experiences; it's not that I'll never get over it but it will always be a part of who I am and um, there are times when I talk about it superficially and I don't have this sense about me that, you know, I have a lot of feelings about it. (#1, p. 46).

While these are only a few of the heartfelt descriptions as expressed by the women themselves, I believe that their richness and their depth of these quotes set the stage for what is to come in the following pages of this chapter.

In an attempt to protect the identity of those involved in this study, I offered women an opportunity for a pseudonym. However, a number of women felt that they wished to retain their own names. These are: Dawn, Natalie, Kanelli, Jennifer, Amanda,
Laura, Vicky and Isla. I will now provide a brief overview for each of the above-named women.

Dawn is forty years old, married and has a four-year old son. Dawn's postpartum depression began when her son was approximately six months old; however, she was unaware of what was happening and did not receive any professional help until her son was eighteen months old.

Natalie is twenty-six years old, married and has two little boys, one two years old, the other, four months old. Natalie was depressed during her pregnancy with her first child, and experienced a subsequent postpartum depression after the birth of her first son. Natalie's postpartum experience was that of a postpartum anxiety disorder characterized by panic attacks and obsessive-compulsive thoughts.

Kanelli is thirty-seven years old, married and has two sons, ages four and fifteen months. Kanelli was born in Greece and immigrated to Canada eight years ago. She experienced postpartum depression with both of her children. She did not receive any help for the depression with the first child, but was hospitalized six weeks after the birth of her second baby.

Jennifer is thirty-two years old, married and has two children, a boy age six and a girl age four. Jennifer did not have postpartum depression with her first child. With her second child, she began having difficulties when the baby was about three months old and this lapsed into a postpartum depression that she dealt with on her own until her daughter was three years old. For Jennifer, two attempted suicides resulted in hospitalization.

Amanda is thirty years old, married and has two daughters, ages two and a half years and four months. Amanda began having difficulty with depression during her pregnancy with her first child. After the birth of the baby, she sought help for postpartum depression when her baby was approximately three months old. She has remained on medication since that time. Since the birth of her second child, she has been managing fairly well but has periodic struggles with postpartum depression.
Vicky is thirty-four years old, married and has a one-year old daughter. Vicky moved to Vancouver during her pregnancy from another country. She began having difficulties within six weeks after the birth of her baby. She sought help almost immediately for her postpartum depression.

Laura is thirty-six years old, married and has four children. She has two teen-age step-daughters, a son who is three and a half and an eighteen-month old daughter. Laura experienced postpartum depression after the birth of her daughter. The difficulties began when the baby was about six weeks old and Laura sought professional help shortly thereafter.

Isla is thirty years old, married and has two daughters, ages four years and eighteen months. Isla's postpartum depression began with her first child, however, Isla was completely unaware as to what was happening and continued on until she became pregnant with her second child. At that time, she was diagnosed with postpartum depression. After the birth of her second daughter, she was subsequently hospitalized and treated with antidepressants.

I have provided brief descriptions of the women involved in the study to introduce some background information that will help to provide a context within which to begin understanding the experiences of these women.

**Why Did This Happen?**

The first category or stage that emerged in the analysis was the need for women to make sense of why they thought they experienced postpartum depression. Although I had a question in my interview guide that addressed the issue of contributing factors, I found that the women were already speaking to this as they told their story. I discovered that they did not always consciously realize that this was happening and this was evidenced by their surprise when I presented the framework to them in our second interview. Some women did not even realize that they were tracking the process, so to speak, yet their individual accounts of their experiences reflected a number of statements whereby they
clearly spoke to those factors that they feel may have contributed to the postpartum depression. As shown in the previous chapters, the existing literature on the causes and contributing factors of postpartum depression are contradictory and multi-faceted to say the least. This is supported by the women's own attribution of cause. I feel it is essential to qualify this statement with the corollary that the women's perceptions and subsequent expressions of cause more accurately reflect the contextual influences of their lives unlike many of the quantitative measures that attempt to categorize women's experiences and attribute cause to simply hormonal or psychological deficiencies. While the women in this study were able to describe a combination of contributing factors, they also indicated that there was no straightforward or simple explanations as to why this experience happened to them. Evidence of this theme will be shown throughout the illustrations that follow. Two properties emerged from the data with respect to the category of Why Did This Happen?: Vulnerability to Depression and Incongruity Between Expectations and Reality. **Vulnerability to Postpartum Depression**

This first identified property of Vulnerability to Postpartum Depression consists of four elements: previous depression, life changes during pregnancy, problematic relationships and ambivalence about pregnancy. Many of the women in this study felt that they were predisposed or vulnerable to postpartum depression because one or more of the above factors were at play. Of course it is important to realize that, and this will be demonstrated throughout the findings, there is no one specific factor that contributes to the onset of depression but rather a culmination of a number of different issues that interplay with one another.

Four of the eight women in the study stated that they felt that they had a previous depression or that they were vulnerable because of a history of depression in the family. Dawn felt that her depression was a learned behaviour.

When I look back on things, I do have a history of depression in my family. Um, both my mother and I would assume my mother's mother although she
died when I was young. And, um, for the reading I have done about depression, they do believe if you look at the medical model there is a linkage whether it be genetic, although I am not sure if I buy into the genetic stuff; however, I do buy into learning depressed behaviour. So, if my mother learned to depress and my grandmother learned to depress, why wouldn't I learn how to depress because that is the behaviour I saw the females in my family choosing. I know as a child I was depressed and again if I think back to my childhood it was and again, with the postpartum depression sort of like the flip of depression is anger so it would not have been appropriate for me to have gotten angry at my baby. No. So postpartum depression made total sense in terms of my limited abilities to choose (#1, p. 36)

Natalie, on the other hand, felt that her depression began in adolescence and spoke also to being treated for depression during her first pregnancy.

I think I was depressed in early adolescence. So that's probably the beginning. Um, wasn't diagnosed though until, I guess it was about a years before I got pregnant. Not even actually, maybe nine months. So, I had just started educating myself about depression and finding out about the treatments that were going to work for me. When I found out I was pregnant, I was taking Prozac. I was on Prozac for about a month when I found out I was pregnant. I stopped that immediately. Actually, I was not too bad throughout my pregnancy I guess the hormones carried me through it. And then after the baby came I was fine. But, then three months after the baby, then it all started to come back (#2, p. 1).

Natalie later speaks to this issue again when she made this statement.

So, that is where it came from. I think I was predisposed to depression and with all the hormonal changes, I think it was bound to happen. And my doctor had even warned me about it when I was pregnant. He said that I would probably have a postpartum depression, about an eighty percent chance (#3, p. 6).

Amanda who also experienced postpartum depression with her first baby also spoke of a history of depression in her family.

Yes, it has been a long haul but you know, the one thing I keep trying to tell myself from as much as I've read and everything is that I have a family history of depression and mood disorders. So, I am prone to it. I keep trying to tell myself that it is not anything that I have done and it's not my fault but society doesn't accept this kind of thing (#5, p. 8).

After Isla recovered from her postpartum depression, she discovered that there was a history of depression in her own family.
I found out that there is a strong depression factor in the family. My mother, my mother's sister, my father's mother went through two spells. My mother's mother went through this. So now I know that (#8. p. 22).

For these women, the discovery that there was a history of depression in their families or the recognition that they experienced a depression prenatally were significant enough factors for them to consider these as precursors to their postpartum depression.

Likewise, problematic relationships with either a partner or mother\(^1\) were described by some women as possible reasons for depression after childbirth. A number of the women spoke of unresolved issues with their own mothers and felt strongly that this was a contributing factor to their postpartum depression. Specifically they talked about how the birth of their child or children forced them to look at their own childhood as they struggled to find their roles as mothers. Thus, those issues that were unresolved in the relationship with their mothers were viewed as possibly affecting their perceptions of themselves as mothers.

Dawn described her sadness around her relationship with her mother and how she had not received what she needed from her own mother and this in turn caused her to question her own ability to meet her child's needs.

The other piece of it for me is about loss and the grieving for the mother I never had even though she was physically present and to realize that part of my process will be a lifelong one. It is integrating what I didn't get into my experience as a mother with Jesse and then figuring out how to give it to myself. And so many of those things I don't even know what they are and they only present themselves to me when Jesse is in a new phase or a new stage or he does something that I've never seen before either in myself or in him. And then I feel the loss of I never got that, this never happened for me, it's not fair. I deserve this (#1, p. 33).

Similarly, Natalie talks about her relationship with her own mother and how this transition to motherhood forced her to look at her own childhood issues.

\(^1\) Are the expectations that women have of their own mothers related to the perpetuation of the myths of motherhood? Does it explain the few expectations of fathers?
And the whole thing with my mother came up when I started in therapy. It's still an issue but not nearly as much. We had a terrible relationship when I was growing up. She is totally delusional. She thinks we had this wonderful relationship. You relive your childhood when you have children so there was a lot of that stuff coming up. A lot of anger at my mother. I still have enormous anger at my mother (#2, p. 11-12).

Likewise, Amanda expressed great ambivalence about her relationship with her parents and in particular, her mother.

I started thinking the other day. I should have been in therapy a long time ago to resolve all this stuff with my parents. I realized when I met with my psychiatrist and she was asking me about my upbringing I thought that this is a pretty dysfunctional family. My father was quite abusive, physically and verbally. And it has taken me a long time...I am still not over that. My mother is the about the most timid person you could ever imagine. And she has no self-confidence, no self-esteem. Never really dressed very well. Never wore make-up. You know, always looked dumpy. I told myself I didn't want my kids to think of me that way. Even when she was here when the baby was first born there was a lot of tension. Dammit, she's not the mother that I want. Part of that is anger. Anger that I have not been able to let go of. I have accepted the way she is for the most part but it isn't one hundred percent acceptance because I feel like I wasn't given the skills. I wasn't taught social skills. Because their own relationship was so dysfunctional. My mom is so passive. She never stands up for herself. Never. And consequently, I never learned to do that and I am still struggling with that assertiveness thing (#5, 2nd interview).

Poor relationship with partner prior to the birth of the baby was also seen to be a contributing factor. Kanelli was very clear about this as is evidenced by the following statement.

I know definitely what the reason was (for my depression) and that was my marriage. It is definitely my marriage to the wrong person (#3, p. 1).

She went on to describe her ambitious desire to move to Canada and create a life for herself but now questions her motives for marrying the man that she did.

I know I got married to him for, well, he's a good man, a decent man but we don't have similar interests. That is the problem. I got married to him because I needed the shelter. What did I do? I ran and sheltered myself instead of going out there and doing it myself. Being brave about it. I was a coward. And I have to mention this, the cowardness that brought me into the marriage
was the cowardness I had when I entered the room at the hospital. Hah! I didn't have the courage to face my responsibilities. That is it. I chose to come to Canada but why didn't I have the guts to do it alone. Instead we got married in a month or so. I was thirty years old. I wanted a family. Fine, we all want a family but how do you do it? Then I just found that instead of going forward I was going backwards. Instead of becoming aggressive I was becoming passive like him. This passiveness brought me into these two kinds of depression I had with my two babies. So it is my husband and myself (#3, p. 36).

Amanda experienced postpartum depression with her first child and a subsequent depression with her second baby. She describes marital difficulties during her second pregnancy that she feels contributed to the recurrence of the depression.

I was maybe a month pregnant or so and my husband started telling me about all these feelings and thoughts he'd had that he had been keeping to himself for so long. Our marriage just got worse and worse and worse and I started getting depressed again (#5, p. 4).

As demonstrated above, unresolved childhood issues with mothers and marital problems with a partner were described by the women as possible contributing factors to the onset of depression.

Furthermore, as women recounted their stories, it became evident that many of them had undergone some fairly significant life changes during the pregnancy which they felt may have contributed to either identified or unidentified depression during the pregnancy. For example, Amanda describes a scenario of events that occurred for her during pregnancy.

I can pinpoint the day I felt I was getting into a bit of trouble. We moved here when I was five months pregnant with her. I had just, if you can imagine having just finished your thesis with an absolutely wonderful defense. Then we went to Europe for over three weeks. We came back and moved. So we had all this happening within two months. So I am five months pregnant and we moved here and I couldn't get a job. I started feeling really depressed and really, you know, bummed out (#5, p. 1).

Similarly, Vicky shares her own thoughts on the events that took place in her life during her pregnancy and the feelings of loss associated with these changes.
We didn't always live here. We moved to this house about the time I became pregnant with her. We moved from the States. So I was dealing with a cultural change, a new country, giving up the place I had always lived, friends and family. And losing a job and having difficulty finding a new one. I know the depression part relates to that...all those changes. It just sort of came to a head (#6, p. 2).

Another type of stressful life change during pregnancy that affected Dawn was directly related to her husband's change in employment and subsequent move to the city. She shares her thoughts and feelings about how his change in job affected their financial security during the pregnancy.

I was angry about the fact that we had just moved into the city and had just got a teeny one-bedroom apartment and I found out I was pregnant. People would say, "so how are you decorating the baby's room, have you got this for the baby's room. It wasn't like I couldn't say there wasn't a baby's room. And that hurt. I couldn't decorate and I couldn't buy things. First of all there wasn't the physical place for it to take place and it didn't fit in with where things were financially. And I thought, "this is going to be the only baby I ever have and I can't believe I can't do this. Um, and I know a lot of what I was feeling I was blaming on my husband and that it was his fault. And even today, a lot of the negative feelings I had about things, I still feel some of that towards him and we haven't sort of worked through all of that (#1, p. 14).

This account by Dawn also demonstrates how relationship difficulties occurred as a result of the job change and subsequent financial concerns. It becomes quite evident that for some women, there is an intertwining of a number of different scenarios that can result in a cumulative effect. The above quotes by these women take into consideration that life changes during pregnancy can create a tremendous amount of stress that, in turn, can be perceived as affecting a woman's emotional well-being after the birth of the baby.

Ambivalence about the pregnancy was another issue expressed by some women. Their feelings and thoughts about this confusing time in their lives are very significant. Natalie candidly shared her own fears about her pregnancy with these two quotes.

Well, when I first found out I was pregnant, I lost it and cried for three days. I completely planned on having an abortion. I went to the doctor and said I was pregnant and he said congratulations. And I said, no, you don't understand. I don't want to be pregnant. He said, "well, why not? You are financially stable
You are in a relationship. You are young. You are healthy. "I'd actually never considered having the baby (#3, p. 13).

I was really freaked out about the pregnancy so I was lucky to have some women to talk to. I married my husband on the condition that he wouldn't ask me for children. And then we got pregnant on the wedding night. So that was a real shock. I was really scared throughout the pregnancy. And one day we (friends and herself) were out at a restaurant and a couple of the women had their babies and they started talking about how to get the crust out of their neckfolds. And I lost it. I burst into tears, ran out of the restaurant and cried all the way home. I looked up the pregnancy crisis center, phoned them and said, I'm eight months pregnant and I don't want to have this baby." I was just freaking (#2, p. 9)

Although Natalie qualified these comments with explicit statements that having a baby was the most wonderful and fulfilling thing that has ever happened to her, her own initial ambivalence about the pregnancy was something she remembers very clearly. In addition, she also further described her sense of relief and happiness when she discovered that she was able to accept and love the baby.

Amanda who was also experiencing some marital difficulties during her pregnancy also spoke to the ambivalence.

So, anyway, the pregnancy went along and I even thought about having an abortion at one point (#5, p. 4).

For Amanda, the marital difficulties with her partner and a previous postpartum depression with her first baby seemed to be contributing to the ambivalence about the pregnancy and she subsequently was treated for depression during this pregnancy.

Looking back on the accounts of women as to why they feel they may have been predisposed to postpartum depression, it becomes apparent that it is impossible to pinpoint one element that solely characterizes the onset of depression after childbirth. Many of the scenarios described are interwoven with one another. This complexity of interrelationships begins to indicate that many pieces serve to create the picture puzzle of postpartum depression. The next element that emerged in the analysis continues to develop a clearer vision of the steps involved in each woman's experience with depression after childbirth.
The Incongruity Between Expectations and Reality

All of the women in this study commenced down the path to motherhood with a vision of what they thought life would be like as they adapted to the new roles and responsibilities associated with the transition to parenthood. Although all women will experience disappointment when their expectations of motherhood do not match the realities, most weather this difficult period and readjust their lives to accommodate all the changes. Others, however, find this adjustment far more difficult. Beliefs and expectations are important determinants of the experience of motherhood. The stories of the women in this study describe the discrepancies between expectations and the actual experiences associated with the adjustment to motherhood. The demands and changes inherent in this transition coupled with any of the predisposing factors discussed earlier may lead any woman to plummet into despair and hopelessness. The women in this study seemed to center their dreams and expectations on seven elements: The birth experience, life with the baby, self as mother, relationship with partner, support from family and friends, life events and physical changes. Expectations may have been developed with respect to these seven elements prior to the birth of the baby while other expectations were created after the arrival of the child. Additionally, their expectations may have been formulated either consciously or unconsciously. The women in this study, as a whole, experienced a series of unfulfilled expectations. Adjustment can be seen as more difficult when the actual experience falls short of the parenting expectations.

Again, I want to stress the importance of realizing that the dissonance that occurs between the reality and the expectations is very complex and convoluted. The women in this study stated very clearly that the cause of their experience is actually multi-faceted. However, they were very articulate in relating how the realities associated to the transition to motherhood compared to their expectations. The discrepancies became a source of shock and discontent.
For five of the women in the study, the birth experience actually proved to be much different than the expectations. Although they were prepared for the fact that there would be some pain and discomfort, the actual events evoked many emotions and disappointments. Natalie had put a great deal of effort into the planning of the birth of her child.

I had a really bad experience with the cesarean. Well, the whole labour was a disaster. I was planning a home birth. A natural home birth in water. And after four days of labour I ended up in the hospital and it just wasn't going anywhere and it was excruciating. Um, so I had the cesarean (#2, p. 2).

She goes on to describe what happened to her.

They froze me too high. And it makes you feel like you can't breathe because they freeze your lungs. I thought I was dying. I absolutely thought I was dying. And nobody was noticing and I was shaking and trying to scream but I couldn't get a sound out. And nobody was noticing this was going on. I don't know how long it went on but it felt like forever. Finally, someone slapped an oxygen mask on me and it started to subside a little bit. It was the most horrible experience in my life (#2, p. 2&3).

Kanelli also experienced traumatic births with both of her children and she clearly attributes her depression to this experience and the subsequent inability to connect with her babies.

I believe that I lost my chance of being happy, having a baby and having all those things you see. A husband beside you, the baby is coming out, the doctor is smiling, everybody is smiling. I didn't know this. As a matter of fact, both babies of mine had to be taken away from me. With the first baby I was thirty-six hours in labour and I was so exhausted and they brought him to me and put him there (motioned to the crook of her arm). My hands were so weak. I had no control and I said not to put him there because he could fall. With the second baby, they brought him to me, I kissed him a bit and I started hemorrhaging. So after a half an hour, the baby went out and I saw him twenty hours after that. So other women take the baby and have the baby in your room. I didn't have that. It was like I was being punished. As if, well, if you want it then have it the worst way you can. You know, being completely slaughtered. The blood I lost both times. It was unbelievable. Why? There are other women. But it was me (#3, p. 17&18.)

Amanda's birth experience was also not as she had envisioned.
With my first baby, the pushing was horrible. And it went on for so long. Her head was big. They used a vacuum and everything. I couldn't talk about her birth for months. I was so traumatized. I couldn't talk about it (#5, p. 31).

Likewise, Dawn describes the birth of her son.

I guess the first thing that comes to mind is the delivery part of the labour is not what I thought it would be. Um, specifically the forceps delivery and the episiotomy. Also, I chose an epidural part way through the process. I was fully dilated and they called the doctor and I pushed for a bit. She said the baby wasn't coming out and they would have to call an obstetrician. She said it was going to be a forceps delivery. I started crying uncontrollably at that point. So of course they did all this preparation behind the drape and I had no idea what was happening in that part of my body. I was so consumed with my own fear and anxiety and I was not into that fact that he was born at all (#1, p. 1&2).

Isla recalls the events surrounding the last part of her first pregnancy and the subsequent delivery.

So I'll start with I think part of my problem and I didn't know it at the time but a part of my problem was going to be my pregnancy. The pregnancy was totally planned and completely wanted but I spent the last eight weeks on one hundred percent bedrest with toxemia so I ended up missing all my baby showers. Those types of things are just enough...I didn't realize it at the time but as I look back on it I think a fair amount of it was missing the excitement of it. Your thoughts of the perfect pregnancy and everything going along tickety boo and then not working properly. So I spent three weeks in the hospital and then my delivery went wrong. I had an emergency cesarean section under a general anesthetic. So that went wrong as well. So I came out of with a c-section which takes eight weeks of physical recovery. So I think that was the start of it (#8, p. 1).

As described above, the actual birth experience proved to be substantially different than was anticipated. The disappointment and feelings of loss with respect to this event continued to be a prevalent memory in the stories of these women. As the women in this study experienced a reality that fell short of their expectations on the birth experience they similarly found that their life with the new baby was not all they expected.

Many of the women described some ambivalent feelings about life with a new baby. These women anticipated that life with a new baby would be a marvelous time. After all, a new mother should be thrilled with their beautiful baby and would never expect
to express any deep negative feelings in the early days. Of course, as these women look back on that time in their lives, they are more apt to see things differently and this is certainly reflected in the following heartfelt statements.

Dawn felt quite overwhelmed with the responsibilities associated with becoming a mother. It was nothing like she had ever imagined as is expressed in the following quote.

And my feelings were that if I had known that this was what it was going to be like then I would have put him back and it was not that I didn't love him but this was not my idea of what I though postpartum would be like (#1, p. 18).

For Vicky, her idea of what a baby would be like was far different than the actual experience of having a baby that was totally dependent.

I definitely didn't think the first three months would be as, well, you know, the baby barely has a personality, doesn't smile and they are just this little eating, pooping and crying machine. I guess I envisioned a baby which is more like what they are like at six or seven months. It took me a long time to enjoy her because I was never getting that image or vision that I expected babies were. Um, I don't know what I expected...just popped out with a rattle in their hand. I definitely didn't have a whole lot of fun those first three months. I mean I was totally baby drunk and I loved her the minute I saw her but it was just a hell of a lot of work that I was not at all prepared for. (#6, p. 7).

She went on to say, with sadness in her voice, that this dependence and hard work also invoked a great deal of fear in her.

And there was this joke we had. I took this picture of the baby sleeping. Well, it wasn't a joke. I think I said it tearfully. The only time I am not afraid of her is when she is sleeping or when she is nursing. So my favourite image of her is in profile because she is either here (motions to nursing position) or sleeping. So, I remember telling a friend of mine that I couldn't wait until she was in kindergarten and she was only two weeks old (#6, p. 9).

Laura recalls her own thoughts of her daughter in those early days.

She was so demanding. She was crying all the time. It was a nightmare. She never had a smile on her face (#7, p. 13).

Similarly, Isla recalls a rough start with her relationship with her baby. She had a difficult birth with a caesarean-section and her child was hospitalized a number of times during the
first year of her life. As a result, Isla found the baby to be very clingy to her and this often became a source of frustration.

She is a cling-on, a screamer, she won't let go of me, she is all over me (#8, p. 5).

Although the women in this study were thrilled with the birth of their children, there were often times when they became quite disappointed with their relationship with the baby and this, of course, did very little to enhance or reassure their feelings about themselves with respect to establishing their new role as a mother.

Expectations of self as mother was another area in which the actual experience of motherhood resulted in some disappointment when the realities did not correspond to the vision or picture. All of the women in this study reflected upon themselves as mothers with respect to their competence and satisfaction with the new role. Expressions of the desire to be the perfect mother and the supermom were dominant themes throughout the stories. However, the ability to achieve these goals was challenged when the realities of the actual experience of mothering was integrated into their lives. Subsequently, feelings of guilt, anger and failure were internalized and infrequently acknowledged. In addition, the recurring theme of loss continues to play a significant role; however, at this point the women were usually unaware of their losses or were unable to articulate the feelings.

These expectations that we have of ourselves as mothers can often be influenced by societal pressure and how we were raised in our own families. Kanelli speaks of how her beliefs of herself as a mother were formed by the teachings of her own mother and how she felt she was unable to stray from those beliefs despite the fact that she was beginning to formulate her own ideas about herself as a mother.

And also I have to be clear that my depression had a lot to do with my mother. How do I define that? I guess each girl's mother gives them the patterns. You have to know how to sew. You have to know how to clean. You get all these experiences throughout your childhood from your mommy. Well, my mother is a very strong person. She was an orphan when she was fourteen. In those
days there was a war in Greece. It was quite a difficult life for her. Her relationship to my father wasn't the best. Well, what did she do? Patience. You make patience of course. That is the pattern, you know, in our culture. Patience. And you raise your children. Now my mother raised me with the idea that you never talk badly. My depression had to do with my mother because I had to follow her patterns. I had to be a mother and not protest about it. (3, p. 20.)

Laura and Vicky both spoke to the expectation of perfection and the imminent realization that this proved to be an impossible task.

I always wanted to have kids. I always thought I'd be the perfect mother. I don't know why I thought "perfect mother." No one ever told me that. I like things a certain way and that is just not possible with children. No one ever told me that. For some reason I kept it together with my first baby and my two older stepdaughters but with the youngest one it was like adding another tire to the car or buying an R.V. The work was unbelievable. So I think that was part of it. I wanted to be perfect. I wanted to be good at my job. (7, p.)

I thought that being at home with the baby equates being the perfect little housewife. It was self-imposed. Make sure the dishes are done first thing every morning, the laundry gets done...but our house has never been like that. Motherhood equates domestic expert and perfectionist (7, p. 8).

Vicky and Jennifer both struggled with their feelings of competency with respect to being a parent. This often had to do with unsolicited advice from people in their lives and the subsequent questioning of their abilities as mothers. Vicky described her experience with La Leche whereby she sought help with breast-feeding. She was given all sorts of advice and in particular, was told to keep her baby in the family bed at night.

I got a call from this woman [from La Leche] and she asked me how the advice was going. She was really pushing for this family bed thing. She started giving me all these statistics about children that don't sleep in the family bed and how they are more prone to SIDS. At that point, I just blew the group off (6, p. 9).

She went on to talk about how feelings of guilt and inadequacy were stirred up within her at a time when she was already experiencing a great deal of vulnerability with respect to this new role.

And each piece of advice whether solicited or not, if you feel you are not doing
something right it really just sort of deals you a blow. Makes you feel like you
don't know what you are doing or that you should be doing something different.
And if it doesn't jive with your instincts, um, it confuses you (#6, p. 10).

Jennifer also struggled with her beliefs about herself as a mother.

One of the other things I saw contributing [to the depression] was that I
did not know what was normal. I remember needing someone to say
that my parenting was normal or that this was normal or that this was
really good. I thought I was doing a horrible, horrible job (#4, p. 14).

Vicky and Kanelli both spoke to the expectation of satisfaction with the maternal
role. Having a child is a truly rewarding and satisfying experience and with this comes the
belief that ongoing bliss and joy should be an integral part of the picture of motherhood.
However, this often is not the case.

I guess there was this expectation that I would love every minute of it. And I
didn't. It was boring (#7, p. 9).

I should have been happy to be a family woman. I should have been happy to be
married, to have children and I was not and I am not. And that was what
triggered the depression (#3, p. 3).

Dawn refers to her perceptions of her own readiness for motherhood and the
realization that this was more overwhelming than she had anticipated.

It was probably one of the few experiences in my life where I've gone into it
and thought I knew what I was getting into but I didn't at all. So, I thought I'd
taken care of everything I needed to take care of and I hadn't (#1, p. 7).

Vicky and Laura similarly described how the reality of the work of mothering was
unexpected.

I can't believe how much work this is. I can't believe how hard this is. This
is the hardest thing that I have ever done. It just overwhelmed how hard it was.
I think I even told a pregnant woman that it is the hardest thing you will ever do.
And that I never...people say to you, "you don't get any sleep, you don't get
anything done, blah, blah, blah. I remember that Murphy Brown episode where
she hadn't been able to get a shower for three days. I remember seeing this and it
was before I had my baby and I thought this is crap. You just don't know until it
is dropped in your lap ( #6, p. 7).

If I could tell someone about parenting I would say it is the hardest job you
will ever have in your entire life and you will wish that you were back at work. I think people have a romantic outlook. It is for the most part an incredibly thankless job (#7, p. 17)

Some of the women also described the expectations they had of themselves with respect to "I should do it all" and how this began to take its toll when it became too much. Dawn described how she came home from the hospital on Friday afternoon and her husband returned to work the following week.

So, Monday he was gone and there I was, alone. Again, it was like this is no big deal. I should be able to do this (#1, p. 10).

Another issue that all of the women seemed to speak to in many different ways was the awareness of a discrepancy between meeting their own needs and meeting the needs of others. As mothers, many felt that the "good mother" would always set aside her own desires and wishes in order to fully attend to the demands of their children, husband and family. Kanelli aptly describes her own struggle with this dilemma.

My depression had to do with my identity as a girl, a woman from my mom's side. You don't look after your needs when you are a mother. You look after your child's needs. But my idea which I had for years is that if the mother is not happy then the children will be happy. So to me everything is different than what they had told me (#3, p. 22).

Laura described her need to get everything back to normal as soon as possible and continue on with life.

After I had her I wanted everything to be back to normal right away and I felt good and thought I was fine so I didn't take any time to relax or anything. We were having parties the week after and not taking anytime to rest or relax. I got mastitis and so I was a wreck and my husband wanted me to keep...he'd taken time off work so he wanted to go to the ball games and go out and see people and I just couldn't handle it. I mean I was sick and I wouldn't give myself any time or chance.

Some women described their inability to allow others to care for their child.

Implicit in this scenario was the idea that absolutely nobody is capable of looking after my child except me and that a "good mother" would never even contemplate doing such a thing. Despite the reality of how exhausted they were and how much they desired a
break, they continued to assume sole responsibility for the childcare. The following quotes from Natalie and Jennifer, best depict this issue.

I wouldn't leave him with a sitter. It was ridiculous. I wouldn't even leave him with my parents. Now, I'll leave him with anybody (#2, p. 8).

I had difficulty letting anybody look after my children. They were precious and nobody could do the job right. You looked at my child, well, I'm sorry but you are not acceptable to look after my child. I know, extreme. But that was the space that I was in (#4, p. 12).

A number of women talked about their inability to ask for help. Sometimes they were unable to even recognize what is was that they needed or they simply felt that it was their responsibility to do it all. In the following two statements by Laura, she seemed to recognize that she wanted someone to look after her, yet she was unable to ask.

I think it was trying, for the most part, trying to maintain what everybody wanted from me. I needed some time and it was like "you guys need to take care of me." But I was so used to taking care of everyone and they were used to that. I was trying to keep it all going (#7, p. 7).

Everybody was the enemy. I just thought, you know, I just didn't ask anybody. It was not....even now it is really hard to ask someone. Not family. There were times when I just thought, god, I'd like to be able to ask someone to help me. I think it would be nice to have help. It is almost impossible for me to ask (#7, p. 16).

Similarly, Jennifer used the following analogy to describe her own dilemma.

And, um, I am woman, I can do it. The other thing was that my peers, I found that the people I was involved with had families as well and their plates were overflowing as well. This family over here, their plates were so full that they didn't stop and think, "hey, let me come and take your kids out for a walk and let you get some sleep or have a bath." It wasn't aware of anybody that had extra energy and I had difficulty asking for help because I saw those people as having their plates full. (#4, p. 9).

She later made the following statement.

It wasn't that the flexibility on the part of others wasn't there, I didn't allow myself that. I didn't know to ask for it. Does that make sense? (#4, p. 10).
Women's ideals or visions with respect to their roles as mothers as compared to what motherhood actually entailed became a series of discrepancies that often led to feelings of sadness, disappointment and loss. Women's perceptions and beliefs about themselves as mothers are an integral elemental part of how women adjust to this new and exciting transition in their lives. However, for the women in this study, the increasing distance between the expectation and reality became a source of discontent. The widening of this gap was often aggravated by the women's inability to recognize their needs and to have those needs met in a meaningful way. The expectations they had of themselves seemed to mask or cause women to set aside their own needs and the corresponding ability to seek out the means by which to have those needs met. This continues to be portrayed with respect to their expectations of the relationship with their partner.

Each woman's relationship with her partner was another area of incongruity between expectations and reality. It encompassed two aspects. The first was related specifically to the amount of emotional support and the second area of expectations centered on the provision of routine caregiving and domestic assistance.

Dawn recalled her expectations with respect to partner support and the strong feelings she began to experience right after the birth of the baby.

It was going to be this time when, uh you know, that the father of my child who has three children from a previous marriage, I mean, I went into this thinking he would know what to do because he's had three other kids. All I did was baby-sit. I totally trusted that he would know what to do (#1, p. 8).

So he would come to the hospital after work totally bagged, would eat the supper I hadn't eaten from the hospital which was totally disgusting and I was thinking why didn't you stop at the Bread Garden? How come you didn't bring me something? This food was terrible. But again I didn't know that I would need those things and I never thought to ask. I just thought he would know. And then he would lay down on the bed beside me and fall asleep. I remember being really disappointed. I just had a baby here. I don't care if you are tired. I don't care if you have a new job. I just had a baby here! The focus should be on me. It's not! (#1, p. 5).

Similarly, Laura who talked earlier about her struggle with mastitis and how her husband's
lack of insight about what she needed at that time caused her immense anger.

We had an appointment at the doctor for twelve. It was the very first day of the mastitis and at twelve he said we had to hurry because we had to get to the game at 12:30. And couldn't he see that I was really sick? And I couldn't tell him and I couldn't ask him, "please can you take me home? I shouldn't be here. I'm really sick. I was really angry at him. And I knew what I needed to do but I couldn't ask. I think it was because I was always making sure he was okay and I assumed that he was always looking at me and seeing if I was okay. I couldn't believe he couldn't see how sick I was (#7, p. 12).

Many of the women expressed dissatisfaction with the lack of practical help from their partners yet at the same time, they seemed to be struggling with the fact that their husbands needed their own space. Vicky was very frustrated with her husband's inability to initiate tasks and then complete the tasks.

This sounds so stupid but I got so sick of reminding him to do stuff or telling him to take the garbage out or the dishes needed to be done. I felt like I was his mother which I sort of always have been. But it didn't make me as angry as before because I wasn't a mother to this one. I mean, I realize he goes to work everyday and he has all that responsibility to deal with so I don't know if I was expecting a lot (#6, p. 5).

Isla, on the other hand, felt that her husband did provide a fair amount of help but again only when she asked for specific tasks to be done.

I got as much help and support as I asked for. On those days he took care of the kids, but if I was doing it then he wasn't going to take over (#8, p. 13).

Natalie was very disappointed in her husband's lack of interest in the baby.

I remember being really angry at him because he wasn't really interested in the baby. But, um, you know the second time around he wasn't that interested. I think that if I recognized what was going on the first time, it would have saved me a lot of anger. Because he'd come home from work and wouldn't immediately come over and start hugging and kissing the baby. And I'd really get upset (#2, p. 10 & 11).

The lack of emotional support and limited assistance with day-to-day tasks was a source of both sadness and frustration for many of the women in the study. Many of the women felt that their needs were not being met by their husbands and, yet for some, the ability to
ask for what they wanted was difficult. If assistance was requested, in many cases their wishes were not fulfilled. The lack of support, both emotional and practical, from partners and the subsequent unmet needs were often mirrored by the shortcomings of significant family members and friends.

The need for support is reflected consistently throughout the stories of the women in this study. Again either consciously or unconsciously, there were expectations of support from family and friends that did not occur. Consequently women were left feeling lonely and deprived of the presence of a support network.

The physical distance between the women and their families was often a concrete reason for the lack of support; however, this realization did little to alleviate the feelings of wanting people present to share the experience of motherhood. Kanelli, whose family lives in Greece, described her situation with respect to her own family.

And I know that, and the other thing, the fact that I was alone here. I didn't have the people I always dreamed of having, like my mother. My mother was not here with both babies. My friends, my good friends. Like I told you every young girl has a dream, "oh, I will become a mother." So you feel like, you think about the scene where everybody comes to the hospital to see the baby. I didn't have any of this. I was deprived of this. I felt extremely deprived (#3, p. 2).

Vicky recalled a scenario from her past that put things into perspective.

I remember helping a woman whose husband traveled a lot. She had a two year old and a baby. But I remember, I would go to her house and stay overnight, help her and she would drive me to school and then take the kids to daycare. I hadn't thought of that in ages and it occurred to me that I was a support person for this lady. Which is what I could have used! I don't have any family here that I can call and say, "I'm sick. Can you come and take care of the baby?" (#6, p. 7).

Amanda's family also lived elsewhere and she subsequently looked to her mother-in-law for support and help.

I wanted this surrogate mother and she just wasn't it. Because I had been led to believe and through no fault of my husband's that I realize now. But his
relationship with her is different than mine is. The type of support she gives him is much different than everybody else's. So the image he has of her and the love that they share is so different than what I would ever get from her. But I was led to believe that she was like that with everyone. So I had this high expectation and when it wasn't met, then boom! I was depressed because I didn't get my surrogate mother that I was sort of promised (#5, p. 13).

Natalie, whose mother lives nearby, describes her anger towards her mother for not being more available to help with the children.

I get angry at my mother that I am not getting more support from her and she is not offering. She comes over once a week but inevitably she is late or she is rushing off somewhere. She's a grandmother and she has nothing else to do. Her main function should be supporting me right now with these two young kids. But that is not the way our society is set up. She won't even change his diaper (#2, p. 30).

Similarly, Isla's family also lived nearby yet the practical support was not available to her. This is evidenced by the following statement.

My mom didn't want to step on any toes. I didn't get any support from the in-laws because...they came and brought beautiful presents but they have their own families. So in terms of actually having help, I didn't get a lot of that. Here, I'll come over for two hours and you go out shopping. I didn't get that (#8, p. 14 & 15).

Dawn's difficult relationship with her own family resulted in the fact that there simply would not be any support available and she is still grappling with this issue today. At that same time, Dawn's expectation of herself that she "should do it all" was a source of contradiction to her when she realized that motherhood was more difficult than she had realized. The following quote depicts her desire to be nurtured and cared for yet she had no family or friends available to her.

It was like somebody was supposed to take care of me and I didn't know how to take care of myself in a way...superficially I do as a person, but not as somebody with a baby. I did not have a clue (#1, p. 15).

She described a scenario that had occurred right after the baby's birth whereby a close friend was supposed to be coming to help her out.
And my closest friend had said to me all throughout my pregnancy that she would come when Jesse was born. She had no idea that it was as big for me as it was because she had people there for her when she had her babies. So, she never came....(#1, p. 11).

In all of the instances cited with respect to the elements of relationship with partner and support from family and friends there is an underlying supposition that all is not well and this support would have been welcomed. Where did the vision fall short? At this point the women are bombarded with a multitude of different factors and things are starting to pile up. During the interplay of all of the previously discussed scenarios there is also the reality of having to deal with life in general and all that accompanies day-to-day living.

Integrating a baby into your life means having to combat not only those day-to-day tasks we take for granted and expect, but also the occurrence of unforeseen challenges or life events that increase the already mounting stress associated with motherhood. Dawn eloquently captures these sentiments in the following quote.

I think I just thought that having a baby and whatever that was about somehow was going to be the only thing in my life. There wasn't going to be any other strains or stresses or anything. If you could just deal with motherhood with a total isolation then it would be extremely manageable. But to deal with motherhood and continue on with the day-to-day living which means you could have tons of stress or no stress, you might have financial difficulties, you might not. It's like...just because you have a baby doesn't mean that there isn't going to be other sort of stresses and strains in your life. And for some reason I guess I just thought they weren't going to be there. So, it was a real shock for me. (#1. p. 8)

For Dawn and her husband, the reality was that her husband started a new job prior to the birth of the baby which resulted in some financial strains. As a result, Dawn was forced to take a job managing an apartment building shortly after the birth of the baby.

There was a part of me that felt good that I took the bull by the horns because I am good at that. But there was part of me that was so pissed off. Why didn't you [husband] plan for this? You should have known. You have three other children. In many ways I am unemployable and I am feeling an attachment to this baby that I didn't think I would and I can't give him up to somebody (#1, p. 12 &13).
Isla and her partner faced a similar stressful situation two months after the birth of their first child, he was told by his company that they were downsizing the number of employees which could result in a possible job loss. They had some serious decisions that had to be made at a time in their life when they felt that they simply wanted to bask in their new role as parents.

So we had serious stress in that I guess I would have to go back to work. So we refinanced our entire life so that if he got laid off then we could survive on my income alone. We did not get an answer to his question about his job for a whole year. After that I went back to work full-time which was a complete contradiction to what I had expected to do (#8, p. 2).

Another practical problem that faced some of the women in this study was related to their partner's hours of work with respect to shift-work or frequent business trips. For these women, there was an understanding that their husband's employment was a necessary requirement for survival but at the same time they felt resentful that they were responsible for the bulk of the childcare. Amanda, Vicky and Isla described their feelings with respect to their husband's employment.

He's been away a lot, you know. There is only one other woman I know whose husband has been away (#5, p. 8).

I found out as I progressed through this depression that I react to people coming and going because my husband travels a lot and every time he goes to leave I would sort of start to panic. I really, really hated his job because he traveled so much (#6, p. 10).

He works twelve-hour shifts. He never works for more than three days at a times but I would go for four days with no sleep and no support and no other adult contact. No breaks. The children were 100% mine for twenty-four hours a day. That is hard. Very hard (#8, p. 15).

Laura and Isla both experienced a great deal of stress related to the illnesses of their children. About two months after the birth of her second child, Laura was dealing with the medical problems related to her older son.

I was devastated. I asked what we were going to do and he said there was nothing you could do. My god, there is nothing you can do. He said he'd have to
have a kidney transplant. I though I just wasn't ready for this now. It was really stressful. I was thinking they just can't fix this now and the other one was driving me crazy. It was really stressful. I've forgotten these things. You know I think of it as such simple things but when you look back.....(#7, p. 15).

For Isla, her first child had a number of different medical problems in the first year of her life. She was hospitalized on three occasions for a fractured skull, testing for possible spinal cord problems and bronchialitis. Some of the comments she made with respect to these incidents were:

Um, I'd been back to work for three weeks when my daughter fractured her skull. She fell off the chesterfield and whacked it on the coffee table. So then we went through the stress of a complete child abuse investigation at the hospital. From there in the hospital they found out that she had a birthmark on her tailbone and at the nape of her neck. The neurosurgeon said to bring her back in two weeks because fifty percent of the time that will indicate a spinal cord problem. So it was another bad experience. Life will get better after this experience. I'm not enjoying life because I am tired and things are not going according to plan. I kept thinking it will get better. ( #8, p. 2).

Kanelli experienced a practical stress related to the physical space of her home; she felt that, in combination with other factors, this lack of space contributed to her depression.

There was a big practical problem in my case. I was living in a house which had no sense of privacy. Underneath there is a small suite. In that suite, my youngest brother-in-law and his wife were living there last year. I asked them to be quiet. You could hear anything in that house. That was another practical reason that triggered it [depression] you know. I couldn't get any bloody silence, any bloody privacy, you know (#3, p. 6).

In many cases, these women assumed that life would carry on in a predictable and fashionable manner as they integrated the baby into their lives. However, in reality, the unforeseen events that occur in life can have a serious effect on how these new mothers cope with the adjustment to motherhood.

Also often unanticipated are the actual physical changes associated with becoming a mother; they include such things as recovery from the birth, breastfeeding issues, sleep deprivation, body image and hormonal changes. For most women, there was a combination of these changes going on simultaneously and that had an effect not only
the physical discomfort of women, but also on the emotions surrounding their perceptions of themselves as mothers.

Recovery from the birth process was a difficult time for Dawn, Kanelli, Natalie, Amanda, and Isla. While Dawn was in the hospital, she was hooked up to an IV, had a catheter and was dealing with the pain of an episiotomy. Kanelli hemorrhaged with both of her births and recalled the following scenario.

I was a wreck because I had a hemorrhage. So that led to an operation and of course, I was alone. I was exhausted physically. I came back home with high expectations and hopes. I was feeling that I would make it and everything would be fine, but physically I was so exhausted I would collapse (#3, p. 4).

Amanda described the excruciating pain she was in after the birth of her second child.

I tore the old episiotomy line and I had a huge third-degree tear. And then when I came home I was constipated. That was pretty upsetting. I was crying all the time from being in pain. I was taking hot baths every night and hot showers every morning to facilitate the healing. Agony (#5, p. 30).

Isla had a cesarean section and recalls her feelings on that time in her life.

So I came out of it with a c-section and eight weeks of physical recovery and dealing with a new baby you never had to deal with before and not knowing what you are doing. Total fatigue. It's like you just keep going and okay after the eight weeks we'll get back up to speed again (#8, p. 1).

Breastfeeding was also a source of physical discomfort from a number of women. There is an assumption that breastfeeding is a natural process that occurs between mother and child. However, the following accounts by Amanda, Laura and Isla confirm that this is not always the case and the physical difficulties that can accompany the nursing process can be painful, which can result in a disappointing experience for the new mother.

The breastfeeding was not that easy with my first child. I didn't know what I was doing. I had sore nipples and I had bleeding nipples. I had all kind of stuff. I was really uncomfortable breast-feeding in public. I felt like everybody was staring at me so that was a big part of my depression (#5, p. 13).

Breastfeeding is hard. As soon as I got home from the hospital I called a lactation
consultant and it was good. But I got mastitis. Oh, man, it came on like this. Fever. Shakes. It was awful. I remember thinking, "I don't want to do this anymore." (#7, p. 10).

So, a week before Christmas, I was nursing her and she was not a good nurser and I had come to the conclusion that we had a latching problem. My nipples were bleeding and I didn't think a whole lot of that because they bled the first time for the first few days until things got toughened up. I was shopping and I couldn't get warm and always shivering and went to the doctor and I had full-blown mastitis, the worse case they had ever seen (F#8, p. 10).

Sleep deprivation was a concern to all of the women that participated in the study. Women attributed this physical exhaustion and fatigue to the onset of the depression. Again, women seemed to have this expectation that they would have this baby and life would continue on. However, they failed to factor in the cumulative effects of lack of sleep. Many spoke of their own recognition for sleep but found that even when they had the opportunity to take a nap, they felt guilty about doing so because it would prevent them from completing household tasks. The following statements by Dawn, Jennifer, and Amanda give clear descriptions of the sleep issue.

And I really believe that before the sleep deprivation got the better of me that I might have called my experience a postpartum adjustment but because I was so sleep deprived that there really were some physiological changes that took place for me that put me over the edge (#1, p. 28).

It was being tired but I don't know how to express that tiredness. I'm not sure how much of that was having one child that is up until 11 o'clock and the other up at 5 o'clock in the morning and then a couple of times in between. Sleep deprivation (#4, p. 2).

And you can talk about sleep deprivation but when you go through it, it is a whole different matter. I find that lack of sleep makes me totally crazy. I'm so crabby. And my temper is so short (#5, p. 1 & 7).

Vicky's struggle with lack of sleep took on a different dimension whereby the constant wakings during the night with the baby affected her to such an extent that she developed insomnia and was unable to stay asleep or get to sleep even when she had the opportunity to do so.
Sometimes I think it [postpartum depression] began right away and sometimes I think it was 4-6 weeks. The reason I say this...is it sort of began right away because I had insomnia problems right away. I know a lot of it was related to sleep disturbances with the baby because of night feedings or not having a long sleep or whatever (#6, p. 1).

Some of the women in this study described their concern about their bodies and the desire to be able resume their physical activities.

I mean I put on 25 pounds and I was a bit marshmallowy but I was back into my jeans thinking, "yep, I'll be getting my body back." My running book said to give yourself four to six weeks after the baby was born and you could get right back at it. I was looking like I would get my body back and I could start running and life would carry on as before. And that wasn't what happened at all (#1, p. 16).

Amanda talked about her sexual relationship with her partner and how her image of her body has created a real barrier with respect to resuming this intimacy.

And then I said to him that my body is so flabby and I don't want anybody to see it. And he said it wouldn't bother him but I said, "well, maybe it won't bother you but it will bother me." It's just...I feel so flabby and so gross that you just don't feel attractive. I think if I got ten more pounds off...(#5, p. 26).

She goes on to be very critical of society's expectations with what she referred to as "thin is in". However, she felt strongly that it is also very hard to be totally free of the images of thin, beautiful women we are bombarded with in the media. She ended this part of the discussion with this statement.

You know, I'm living in tights and baggy pants. There is nothing that fits me and I don't want to go out and spend a lot of money. But I hope to be losing all this weight within the next years or so. It's hard. I'll do what I can. So, yeah, it's real hard to do the self-care thing. It's hard to feel good about yourself. Like the first week or two you don't mind but at three months it is kind of hard to take (#5, p. 26).

Another physical change that some women spoke about was the hormonal changes associated with childbirth. Although their feelings were mixed as to whether or not these changes actually contributed to the depression, they did describe some of their ideas with respect to this issue. For example, Kanelli shared the following thoughts.
That is why I will be very interested if they come up with a definite thing about this postpartum depression. Is it also physical? Because I had the physical. I told you about all the psychological. But I also had a physical because every time my brain would start working at a thousand spins in a minute I would go completely crazy or do something bad. Then I would step up on the bicycle and by exercising I could feel something running around my spine. It felt like water coming from my brain and running down my spine. So that is why I say it is physical. And if it is physical, is it just hormones? I believe that you are stricken with two major elements at the same time: A huge change in your system with a baby being taken out of your body. And also the new baby (#3, p. 27).

Dawn and Natalie also questioned the role of hormonal changes.

I felt like there was something going around in my system. So I think it was about hormones but I'm not positive (#1, p. 14).

I think I was predisposed to depression and then with all those hormonal changes, it was bound to happen (#2, p. 6)

The range of physical changes that occur for women after childbirth play an integral part in the emotional adjustment to motherhood. Generally, women do not anticipate that the physical demands placed on their bodies will be as dramatic as they in fact are. Physical pain and discomfort from the birth and breastfeeding, not to mention the known effects of sleep deprivation are clearly described by the women in this study as the realities of what actually happened to them.

Interestingly enough, the continued themes of loss and unmet needs has emerged throughout all of the elements described with respect to the incongruity between expectations and reality. Loss most often occurs as a result of change and it is overwhelmingly clear that these women have experienced monumental losses that are directly related to changes in relationships, changes in the self in adapting to a new role and the changes associated with the arrival of a new baby in the family. In addition, the series of expectations that women carry with respect to the birth, their view of themselves and mothers and the people in their lives are most often unattainable. That is to say, the setting of one's expectations at a high level may increase the probability of disappointment and disillusionment. The very existence of the single expectation of being the "perfect
mother" or the "good mother" negates that same individual from seeking assistance or help from others. To seek assistance would be to admit or show that a very important expectation of being a perfect mother is not a reality. At the same time, because women often portray themselves as competent and able, those around them do not perceive that support or assistance are even necessary. Additionally, there is often the underlying assumption that women should be able to do this on their own anyway. I believe that the interplay of all of these factors would lead any person to feel a sense of disappointment and disillusionment not only with themselves but with the significant people in their lives.

After this initial stage of determining why this happened to them, these women moved on to talk about a second stage of how the onset of the depression began to affect their ability to function and they began the process of spiralling downwards.

**Spiralling Downwards**

Spiralling downward represents the process by which women began to move beyond the typical adjustments associated with motherhood and are pulled into an absorbing and powerful vortex. I must stress the importance of maintaining a clear perspective in that this process is by no means a linear process but rather one that is more circular in nature. Women are not simply sucked down in one sweeping movement but rather resurface for air many times. Spiralling downwards is the second category or stage identified in the data and includes two main properties: **shattered dreams** and **losing control**.

**Shattered Dreams**

Based on the stories told by the women, **shattered dreams** consists of three elements: the changing relationship with partner, the disillusionment with motherhood and the questioning of who they are. As the women looked back on their experience with postpartum depression, they were able to see a cumulative effect occurring as depicted in the first category: Why Did This Happen? They began putting the pieces together as to why they experienced a postpartum depression. At this point, in the stage of spiralling
downward, the women, although often unaware, are in the early stages of the depression and their outlook with respect to their lives as a whole has become somewhat grim. Themes of loss, particularly in relation to their perceptions of themselves as mothers and as women continue to dominate this category.

**Changes in relationship with partner,** although prevalent in the first category, has now begun to take on a somewhat different flavour. The outlook has become somewhat more dismal and dark. Again, the theme of loss emerges as Dawn succinctly describes her thoughts with respect to her partner.

As much as I had agreed to have a baby, I only did it because, again, his sentiments were I want to have a baby with someone I love. And, so I thought, "here are two people who love each other. This will be a joint project together and it will make a relationship that is good, really good. That wasn't the truth. That is not how it ended up being. And it still isn't that way and it is almost four years later (#1, p. 7).

At this point Kanelli, whose descriptions of marital problems prior to the birth of her children were heard earlier, has taken on a much stronger tone as she so clearly states in the following statement.

He might be a good person, a good man, a good father. It was like something blinked and I just woke up and discovered there was nothing to be happy about. Nothing to share with this person (#3, p. 2).

Similarly, Vicky talked about the initial stages of her depression and how this affected her relationship with her partner.

He was really upset about all of this. He felt guilty about having to work so much. Our relationship wasn't the greatest and there are still elements of that. So. we went for a couple of sessions to a marriage counsellor (#6, p. 4).

She went on to describe her concerns about the marital relationship as it related to adjusting to a new way of life.

I suppose most of what I was disappointed in was how come he couldn't change so much. In my perspective he hadn't changed. He probably did. But in my perception he still got to go to work. It didn't seem to change for him. Of course it did. Neither one of us had the freedom to just go. But to me it didn't seem like
he changed as much as I did. I don't know if that is selfish or not but that is my perception (#6, p. 14).

Inherent in her words was once again the theme of loss. Similarly, Jennifer spoke of her own marital difficulties. As she began experiencing some initial difficulties with depression, her partner, in an attempt to help out, began to take over many of what Jennifer had viewed as her responsibilities in the home.

I lost, for me which was significant, I lost the territory of my house. When he was stressed, his way of coping was to over control. So, between us it was an uneven equation. A loss of power. We had agreed that I would be a stay-at-home mom. I'd do the laundry on Wednesday, I'd cook the meals at five o'clock. And, um, he wasn't able to give me the space and I wasn't able to take the space. My attitude is still that he won the territory of the house. He still does all the laundry, virtually all the cooking. So I lost my role, what I thought was my role (#4, p. 11).

Isla expressed the change in relationship with her husband with respect to their sexual relationship. She experienced a great deal of guilt about her lack of interest in intimacy with her partner.

You feel you are a mother, homemaker, but you also have the job of being a wife and a wife includes physical intimacy. That changed seriously. I was not pressured but it was always in the back of my head that I was failing in the wife department (#8, 2nd interview, p. 1).

Similarly, Natalie discusses her thoughts on the same issue.

I guess I should mention the whole sex thing. Um, basically, we just haven't had sex more than a few times since we got married. Prozac diminishes your sex drive. I'm still nursing. I just don't want anybody touching me. That is probably the biggest problem in our relationship (#2, p. 17).

Changes in the marital relationship occurred on many different levels. For these women it appeared that the changes in the relationship and the subsequent losses associated with these changes became a source of disappointment and discontentment.

At the same time, the disillusionment with motherhood was illustrated in the women's stories on a number of different levels. Some of the women had an awareness that things were starting to take a downward shift and while they struggled with the day-
to-day responsibilities of motherhood, they were still making attempts to develop
strategies or ways to make themselves feel better. Jennifer shared her struggle to deal with
the day-to-day activities associated with motherhood and her attempts to overcome the
feelings of discontent.

Um, the hurdles to overcome seemed colossal. Getting out the door, getting
the children dressed, getting your diaper bag ready. Thinking of all the little
things that you needed to pack. It was like going on a three-day holiday to go out
for three hours. And to not have the energy to do it. I don't know where you get
more energy from at that point in time. So, I tried mega vitamins. I remember
trying to be more structured. If only I was more structured, things would be more
predictable and I'd be able to get a grip. I tried being less structured. Well, maybe
if I just go through the day and just let it happen, then I would make it through the
day (#4, p. 8).

Likewise, Isla recalls doing what she referred to as "self-analyzing." She remembers
feeling overwhelmed by the amount of work and struggling from day to day. She
described herself as a goer and a mover and she began trying to figure out different ways
of coping such as attending mother and tot drop-ins and fitness classes. She tried all sorts
of different ways to meet people but she became more and more discontent and eventually
began feeling resentful.

I can't do this...the I can'ts because I have a child. I can't start this project because
I have a child. I can't clean the house because I have a child. I can't go grocery
shopping in peace because I have a child (#8, p. 6).

A further demonstration of this struggle is exhibited in the following quote by
Dawn where she expresses her ambivalence about motherhood simultaneously combined
with the desire to do what was best for her child.

Even though this was the hardest thing I've ever done, it was so difficult because it
was like a double-edged sword. It was like I don't want to do this and I don't like
this. And this is menial and this is degrading and it's like a bloody assembly
diapers, changing, washing, feeding. And I had a huge need for freedom so it
was so hard to feel like I was attached to this little person. I just wanted to get
away. I just didn't like that feeling of someone being so needy yet I breastfed for
thirteen months. So, I am a contradiction. There was a part of me that felt that
my mother never did this for me and this is the best thing for my child. I really
want to give him a head start on everything and yet there was a cost to me and I
guess it wasn't until the cost became too great that I began to find another way to
do it (#1, p. 13).

Dawn and Kanelli both spoke to the permanency of motherhood and how this
overwhelming responsibility was very difficult to accept. Dawn's description of this issue
was captured in this simple but strong statement.

But, I will always be a mother. It doesn't matter if it is 5:00 or Saturday or
or midnight. I just realized that this is forever (#1, p. 10).

In a similar way, Kanelli uses the following analogy to describe her feelings towards what
she called, an "irrevocable way of life."

Let's say, if you go to university and take three years of law and you hate it,
then you can change. That is fine. It is revocable. Sure, it is revocable. Sure,
you lose your money and your time. But here it is not revocable. You can't say
sorry I don't want him. It was fine for six months, take him back. For me, this
permanent thing was the hardest (#3, p.22).

Isla recalls feeling overwhelmed by all the things going on in her life. Between working, a
sick child and financial stress, she remembers two thoughts that haunted her mind.

Life was ugly and I hate my life were two of the terms I was using at that time.
Sort of dragging myself from day to day. That is when I started talking to my
doctor. I was saying that I am not liking this, or I'm very lonely at home or my
daughter is driving me bananas. Those were the kinds of comments coming out
of me to my doctor, to my husband. Not necessarily to anyone else (#8, p. 5).

This disillusionment with life and motherhood continued to be in direct conflict
with all those expectations that these women had of themselves as the perfect mother.
These feelings of sadness and despair served to pull these women further into the depths
of the dark, swirling waters.

As the disillusionment with motherhood began to take it toll, women often began a
personal struggle with their own identity or began asking the question, who am I? To
ask the question underlies a sense of loss, in this case a loss of self. Jennifer's use of the
following metaphor aptly depicts the reoccurring theme of loss.
You know how water runs over the rocks and it eventually smooths them down and then you end up with this Grand Canyon. Well, that was very much what it was like. You can maintain your boundaries for so long, but the water wears you away. It doesn't matter if you are made of rock or steel or you are made of paper, the water wears you away. And my identity very much. I lost completely who I was. Completely (#4, p. 4)

Dawn reflected back on her perceptions of herself as a mother and her difficulty in integrating this role with the rest of her life.

When I would watch women out there they were smiling and happy and they loved their babies and they were doing all these things and that was fine. I didn't feel that way. I never saw myself as I saw any other woman out there with her stroller, her baby, at the park. I mean, I would be at the park and look at other people and think, oh, they are mothers. So are you. Whatever it was they were, it is not how I saw myself (#1, p. 40).

Kanelli also recalled the strong feelings she had about the mothering role, the loss of freedom and her inability to maintain a sense of who she was as an individual.

To me, I really define it, how can I say it, I just rejected my life. I rejected the idea of having children, having children with this man perhaps? Or just having children. Or was it the idea that I lost my freedom? Perhaps. Sometimes when I think of it I think it might have been that I lost my freedom and not knowing me anymore. It was so strong for me to lose my individuality, my independence (#3, p. 14).

Although the struggle with self-identity as a mother was prevalent in the first stage, Why did this Happen?, the struggle with self at this stage in the process has shifted to an absolute and debilitating loss of identity, not only as a mother but as a person.

**Losing Control**

The women were able to identify a certain point in the process when everything began to change in a very dramatic manner. There was a sense of things happening to them that were beyond their control. **What is happening to me, isolating the self and falling off the edge** are the elements of this property.

When they recall their lives at that time, the feelings of **what is happening to me** were starting to surface. Many of the women described their inability to make decisions,
continuous crying, anxiousness, panic attacks, and raging anger. At the same time, however, many of the women felt a huge desire to maintain an image. Often this had to do with not feeling safe to discuss these intense emotions. Again, this relates to the pressure to conform to the role of the good mother. A good mother would never feel this way. Some women, on the other hand, began to speak about the turmoil and despair but recall minimizing the feelings or, in fact, were not expressing their feelings loud enough for others to hear.

Dawn illustrates a series of issues that were happening for her all at the same time and show how she struggled to maintain an image.

I mean, things that to me would have been no big deal became huge. Everything was huge. Doing laundry, making meals, getting Jesse ready, changing diapers, just everything. The only thing I managed to on a regular basis, well always I did, was I always had a shower, I had good looking clothes on, my face was made and my hair was done. And I said then it is called a designer depression. Because, for me, it was, you might call it a face. It's my safety. It keeps me...I've often said to people that if you see me out and about and I hadn't had a shower and I was totally grubbed out then just know that I am feeling so good about myself that I can't stand it. So the fact that it's hard for me to feel good about myself so if I at least looked put together then that helps. It helps. But everything was just too big. I couldn't cope with the smallest things (#1, p. 38).

Women often described how they could see things changing and how feelings of losing control accompanied that change. Jennifer recalls the following images.

And, um, what was scary for me was how I saw myself changing and I thought I could have control over it. What was scary was having the emotions so strong. I'd put the baby in the crib and I'd walk away and close the door. I never told anybody about this. I'd pull my hair. Just to relieve the tension. Or I'd bang my head on the wall. I got to the point where I wasn't doing my daily routines. The depression was affecting the daily routine. I wasn't looking after my hygiene. I wasn't going out to do the groceries. If I went to do the groceries, I was always with the children. I think the thing about that space was that you are hypersensitive to stimuli so the sound would just ricochet off you and it was like your skin was vibrating (#4, p. 3)

Laura also provided an account of her own realization that something was wrong but her inability to control it was stronger than she could have imagined.
So I think I started to get...whatever...depressed or something was happening to me that I couldn't control. We went away for the weekend and that is when I figured something was terribly wrong. We went down to our cabin for a long weekend and there were twenty-two of us and me and my sister-in-law were cooking for everyone and I just thought I was going to leave my husband. I thought that this was it and I could not be married to him anymore. I didn't want these children. I hated everybody. Hated this place. I hated everything (#7, p. 2)

Similarly, Natalie has vivid memories of the anxiety and the uncontrollable desire and need to keep busy.

Um, a lot of the obsessive-compulsive thinking, playing the scenes in my head. Usually, it was bad experiences from my past and it would just go over and over in my head like someone was forcing me to watch a movie and I can't turn it off. Also, I get really anxious and irritated and wake up in the morning and I just couldn't wait to get out of the house. I just had to go and do something and keep busy, busy, busy, busy non-stop all day until my husband got home. I was okay once he got home because I didn't like to be alone in the house with the baby. And then, the anxiety and panic attacks started(#2, p. 2).

Looking back on the experience, Isla recalls her depression as a time of incessant clock-watching and constantly trying to figure out how she was going to survive the day.

A very strong sign of my depression was clock-watching. An example of a typical day. I don't know what I am going to do for the next sixteen hours. I have not an idea what I can do. You go through the process of feeding them, dressing them. You sit on the floor and play with them and I guarantee you that I looked at the clock every two minutes all day long. My entire thoughts were fifteen hours and forty-two minutes to go. No I have fourteen hours and fifty-two minutes to go. We made it to lunch. We've got ten hours to go. We made it through nap-time. We have eight hours to go. You get into bed and then all night long...I've only got six hours to go, I need to get some sleep. I've got five hours to go, I need sleep. I've only got three hours to go and I still haven't fallen asleep. I spend all night dreading the morning. The dread of having to face the day (#8, p. 12).

Kanelli had a similar way of describing her feelings with respect to the dread she felt with the arrival of another day.

With my first baby, I hated the nights. When night came, I was devastated. With the second one, I hated mornings. I don't know why. Morning came and the new day was out there and it was, "how am I going to make it today?" Another day. And then I had to drag myself, wake up, stand up, move, move, move. I hated it. I just completely hated it (#3, p. 15).
Many of the women had no idea whatsoever that they were suffering from postpartum depression. They simply continued on day-by-day while the feelings of inadequacy began to mount. The following quote by Dawn represents her own feelings at that time.

"It never occurred to me that there was something wrong with me in terms of postpartum depression. What occurred to me was that I was the most inadequate human being on the face of the earth (#1, p. 20)."

During the time described earlier when women were feeling disillusioned with motherhood they were still seeking ways to make themselves feel better. However, at this point many of the women had completely abandoned all attempts of finding ways to cope and this resulted in an increasing isolation of the self. For Dawn and Jennifer this was related to the fact that the depression was so incapacitating that they simply did not have the means with which to pursue outside contact.

So it became, "this is a struggle, this is really hard, I don't like doing this and this wasn't what I had bargained for." And so, the days became, you know, Jesse napping when he napped. I didn't always do things then as much...as I didn't sleep. I might lay down. I would try and do something but I didn't have the stamina. I just couldn't. My husband would get home from work and the place was the same as when he left in the morning. Dishes wouldn't be done, meals wouldn't be made, wouldn't have ventured out anywhere. Would have just stayed in the suite all day unless somebody phoned. So I was sort of creating more of a dungeon for myself (#1, p. 19).

Jennifer's experience was similar; however, she had a physical response to the stress associated with making an attempt to get out the door.

"I couldn't get out the door. By the time I had the children dressed, I could feel myself shaking. And that creepy crawly feeling was there. And to get out that door. To get out that door. And to face people and make conversation. I wasn't able to make conversation (#4, p. 7)."

At this point, women's perceptions of themselves became very negative. Self-doubt, self-criticism and self-hate were words used to describe the intense feelings they had about themselves at this point in their lives. The following quote by Dawn depicts her own feelings about herself.
I felt lethargic, de-energized. I despised myself. I felt really lousy about myself. I questioned my core beliefs, my values, my goals, what I wanted out of life. Everything. I just thought that this was the damnedest trick (#1, p. 20).

At the same time, intense feelings of anger were described by many of the women. They were most often unable to determine the source of the anger but those expressions of anger were often a source of energy that motivated them to keep going. Natalie talked about her own anger as follows:

Anger was another big one. My poor husband, and he got the brunt of that. I don't know where it was coming from but it wouldn't take much to set me off (#2, p. 4).

Similarly, Laura describes her own experience with anger.

And anger. God, I was angry all the time. So mad! I didn't hit anybody or throw things but I would just scream at the top of my lungs. It was like an earth-shattering screaming (#7, p. 4).

At this point, the feelings for these women have become overwhelming and unmanageable. Simply managing on a day-to-day basis often became an almost insurmountable challenge that added to the frustration and despair. Finally, the plummeting downwards became the only alternative.

Falling off the edge was described by all the women in the study as reaching the place where it felt like they hit a brick wall. Something happened that resulted in a realization that this was a serious matter. For each woman in this study, falling off the edge meant something different and in fact it is better conceptualized as a continuum that included not functioning on a daily basis, to complete insomnia, to thoughts of hurting the baby, to attempted suicide and even hospitalization.

Isla, who describes herself as completely unaware of that fact that she was now depressed for almost two years, shared a series of different scenarios that played out for her when she hit a crisis point.

At this point in time, the feelings are strong. We are reaching crying all day long
and when the three-year old got to be too much or the overwhelming feelings I would go into the corner of my room and curl up into a little ball and cry and cry and cry (#8, p. 8).

In the following two quotes, Jennifer adds additional depth to this phenomenon as she describes this time of blackness and hopelessness.

For me that was the crisis. You can go in a sense of being in a fog, a sense of unreality, a sense of disassociation, almost. You just keep going, keep on going. You just plod it through. You have no emotions. You are completely numbed out. You have no energy. Talk about Duracell batteries. Women have a far stronger battery than Duracell could ever make (#4, p. 7).

I wanted to cut myself up into little bits and throw myself to the wind. I wanted to scratch myself, to claw myself. Just totally weird stuff. For me. So there was going from this numbness to the "too much" feeling (#4, p. 19).

Suicidal feelings were a common thread for a number of women. Some of them went so far as to actually plan how they would end their lives but how thoughts of their children prevented them from following through on this desire. Dawn recalled that time in her life and made the following statements.

I was thinking about ways to get rid of myself. The only thing that kept me from doing that was that I knew that Jesse wouldn't be okay. I was the only person in the universe that could take care of him. How could I be so incredibly selfish even if I was hurting so much? (#1, p. 32).

Kanelli also experienced thoughts of hurting herself in conjunction with thoughts of hurting the baby.

There were moments when I was opening the can, the Enfalac, and the moment I opened it I wanted to take a knife and cut my wrists. And that is what I really wanted. And there were moments, I have to tell you, just when it hit me and it was snowing and I wanted to take the baby, let him out, to freeze (#3, p. 5).

For Jennifer, however, the thoughts of suicide actually became a reality in that she did attempt suicide on two different occasions. She shared her thoughts about this devastating time.

Why I overdosed was that I truly believed and I cannot understand how I could be so sick but I truly believed (crying) that my children would be better off without me because I was screwing them up (#4, p. 14).
Kanelli uses the metaphors of "going down through a tunnel" and "a fire within me" to describe her experience just before she was admitted to the hospital.

What happened was I started vomiting. Every morning I would wake up to go to the bathroom and just empty my stomach which had nothing. And, um, when I came out of the bathroom I was going into the living room and I was taking a position like...(demonstrated the fetal position). I was crying and saying, "I'm sick, I'm sick." My husband was there and asked what was wrong. "Take me away. I am sick. I am ill. Get an ambulance." That was the only thing I was saying for ten days. And then eventually I called the ambulance myself (#3, p. 5).

Based on the above examples, these women's memories of this devastating time in their lives remain vivid and clear. Their pain and suffering can be felt in the words. They had reached a place of complete helplessness and hopelessness. However, this experience of bottoming out or falling off the edge also became a turning point in their recovery from depression after childbirth.

**Getting to the Other Side**

The third stage or category that emerged from the stories of these women related to their own recovery and healing process. The shift from Spiralling Downward to Getting to the Other Side was not a linear process but could be likened to that of a roller coaster or a spring whereby there were many ups and down before the women actually recovered from this time in their lives. Getting to the Other Side includes three properties: **Surrendering, The Creating of Hope** and **Rebuilding the Self**.

**Surrendering**

The concept of surrendering is not so much the idea of giving in but rather represents the recognition that something extremely serious is affecting every corner of these women's lives. Dawn describes this time as the "waving of the white flag" whereby she acknowledged she could no longer allow this phenomenon to control her and she began to seek out ways of determining what was happening to her. Similarly, Laura recalled her feelings of "it got to the point where I had to do something."
Women's perceptions and experiences with depression after childbirth directly affected their help-seeking behaviours. Despite the misery and disruptions created in their lives, most of the women in the study did not seek help until they had reached a crisis point in their lives. While some may have began seeking help in the earlier stages of the depression, their cries for help were often minimized or ignored. There was great variation in how women discovered what was wrong and the following quotes will provide a picture of the various experiences of the women in this study.

A number of women were able to identify their postpartum depression through reading books or articles. Laura recalls the following.

I thought there was something wrong with me and I went to a book that I had and I looked up postpartum depression and I thought, "that is it, that is what I have." I mean...I guess it started...I had her in August and I figured it out at Thanksgiving. So it was a couple of months before I figured it out (#7, p. 2).

Similarly, Dawn, who struggled for more than a year with her depression and had no idea that she was depressed, recalls her own realization. Coincidentally, she was seeking some practicum work through her schooling and the Pacific Post Partum Support Society was suggested to her because of their volunteer program. Upon receiving some written information from them, she recalled the following.

So, I read that and I thought, "oh, my god, I am postpartum depressed." I'm in between stage three and stage four. Because I had always thought postpartum depression was about hormones and happened right after the baby was born. So, when someone suggested after a year and a half that this was what was wrong with me, it was like, you have got to be kidding. No! So, when I read that, there was an openness to look at this (#1, p. 22).

Women also approached their family doctors with their concerns and had varying experiences with this means of seeking help. Laura experienced a somewhat devastating experience.

My doctor was on a maternity leave so I saw a locum. And I went to her and I brought the baby because there was something wrong with her and I said to the doctor that there was something wrong with me and I had postpartum depression. And I started to cry. And she said, "well, let's not talk about you
right now. Let's look at the baby." So, I was trying to hold it together so we could discuss the baby and then she said, "so, you think you have postpartum depression?" I told her that I thought I did. She said, "well, you will have to stop breast-feeding so I can give you some pills. And I said that I couldn't do that because to me that would equate with being a bad mother. I was already a crappy mother in my own eyes anyways. So stopping something that everybody said is the best thing for your baby and I would have to give it up because I was broken or something. She said she'd call me back that evening and she'd try to find out what I could take. She called back and said there was nothing she could give me unless I stopped breastfeeding. She made an appointment for me that was with a psychiatrist but it wasn't for six weeks. She then said, "if you need anything else, then give me a call. I was devastated...so devastated (#7, p. 3).

Amanda felt that her experience with her doctor was very supportive. However, the difference for her was that she knew about postpartum depression prior to having children so when she began feeling depressed, she very clearly sought the necessary help from her family doctor.

I told my doctor at the first month when I brought her in for a check-up that I was feeling crummy. He said, "we'll keep an eye on it." At that time I found him fairly sympathetic. An then at six months when I took her in for her needle I said to him that things just weren't working and that I needed to be on medication. He said okay. (#5, p. 2).

Isla, who was depressed for two years and also did not realize she was depressed, had been talking with the occupational health and safety nurse at her place of employment about an unrelated topic. She recalls the following chain of events.

I was in her office for an hour and a half and by the time I came out of that office we came to the conclusion that I was the person that had the problem. It was the occupational health and safety nurse that determined or suggested I was depressed (#8, p. 7).

Isla, who felt that she had presented some warning signs to her doctor already, went to her doctor again to discuss the matter further and although she found her doctor very supportive, remembers the following scenario.

So, the occupational health and safety nurse suggested I go to my doctor and say the words, "I am depressed" as compared to hinting at it. So when I went this time I said I was depressed. She said, "how come we haven't picked up on this before?" She started flipping through the chart and reading her notes. It was all
there. She hadn't put it together. I usually came in with the kids, not for myself. These had been just little comments (#8, p. 8).

Many of the women felt that they had tried to let various people know that they were not doing well and for whatever reason, they were not taken seriously. In the following two quotes, Jennifer, who was depressed for three years, also recalls trying to let her doctor know that something was wrong and her subsequent more forceful pleas for help.

Um, I am sure that I tried asking for help. Obviously, it didn't come across somewhere in the communication process. Nobody heard I was desperate. Part of that may have been how I expressed that. The fact that I had said to my doctor in passing that I think I'm getting depressed or some very blasé kind of statement when the kids were getting their inoculations (#4, p. 8).

The summer that my second child turned three and I was still having all these experiences, um, I went back to the doctor. I told him that I wasn't kicking this and that I was not prepared to take antidepressants (#4, p. 2).

Kanelli, who was depressed for more than two years, did not receive any help with the depression with her first child. She was hospitalized six weeks after the birth of her second child and upon discharge from the hospital, she received a visit from her health nurse.

A nurse phoned me from the health clinic. She said she wanted to come and see me and when she came I mentioned the depression and not being well. She asked me if I'd be interested in joining a group and I said okay(#3, p. 19).

All of the women in the study participated in the support groups of the Pacific Post Partum Support Society. All of the women except one cited this agency as an integral part of their healing process. Usually, the women were attending the groups while also under the care of their family doctor. As demonstrated in these help-seeking behaviours, there was great variation in when women sought help and in how the help was provided. The significant point to bear in mind, though, is that in most cases the majority of women did not seek assistance for their depression until they had reached a crisis point. Their perceptions of their depression had important implications for help-seeking as will be demonstrated in the following section.
Once the women did seek help, dealing with the label of depression was often a source of concern. Women's reactions to the label of depression encompassed two types of responses. Many were relieved to be able to put a name to their experience. However, the stigma often associated with the word depression was to become a source of embarrassment.

For Dawn, her initial reaction to the suggestion that she might have postpartum depression was that of disbelief and outrage.

I phoned a support group and the woman on the phone suggested that I was postpartum depressed. I mean, I got my back up right away. It was like, "get a life, I am not. How dare you categorize me and say there is something wrong with me." I never went (#1, p. 21).

However, once she had time to process the information, her attitude began to change. The sense of relief, normalcy and realization that she was not an incompetent mother are reflected in the following quote.

I was like I am something, I can call myself something. I am not a terrible person, I am not a disgusting mother. Suicidal thoughts, all the things that were going on in my head, other women thought, too. It wasn't just me. There was some normalcy in that. I felt validated. Um, right away there was a sense of ...maybe there was a way out of this. Maybe there is a solution. Other women have felt this way (#1, p. 22).

Similarly, once Laura realized she was suffering from postpartum depression, she felt an instantaneous sense of relief.

So after I figured out what it was, I phoned the doctor right away and I phoned my husband right away. I said, "I know what I have. I'm sick." And I felt very relieved to say I was sick. When it doesn't have a name attached to it you just think it is you and your personality has changed and this is who you are going to be for the rest of your life. And then it was like, "wait a second, I am sick." Now I can blame it all on the sickness and not on myself anymore (#7, p. 2).

Natalie, on the other hand, experienced embarrassment because she felt that there was a stereotype of postpartum depression in that people would automatically think you are going to kill your children. She worked very hard to maintain what she called the
"supermom" image and refused to believe that she had postpartum depression. She recalls her initial feelings at her support group.

I would be sitting there shaking, fidgeting with my legs and bouncing on my chair and I kept saying, "I don't know why I am here, I am not depressed and I don't know what the hell I am doing here" (#2, p. 5).

Some women found it very difficult to talk about with other people because they felt they would be judged or viewed as "crazy." Laura, who earlier stated that she felt relieved to have a label of postpartum depression simultaneously struggled with the following contradiction.

And so after a month of this (the depression), my husband mentioned it to a very good friend of mine. Somebody I hadn't told. She phoned me up and I was so angry. I said to him, "I can't even tell my own mother or speak the words to my own children that I was sick and having a terrible time." I begged him not to speak of it. It was shameful. So shameful to be sick. I don't know why. Because it is a sickness in your mind and you know, you're crazy. People think that you are nuts. And if people do, they still don't understand or they tell you to go for a walk and then you will feel better. I'd have to walk to China (#7, p. 8).

Amanda also talked about her own struggle with the label and the inability to disclose her feelings and thoughts. She clearly demonstrates this in the following quotes.

But, it is a stigma, you know. I find that it's not one of those things where you can say you are diabetic or whatever. People just don't want to hear about it so you just sort of learn who you can talk to and how far you can go with what you tell people (#5, p. 14).

So, it has been very strange that way like feeling you have to keep it a secret from certain people. You know. And then they won't have any sympathy anyway so why bother. I don't have this need to tell people. I know who is going to be understanding and who won't. And some people are not very understanding about anything to do with the mind as opposed to being physically sick. Physically sick is more acceptable. Like somehow I could have helped this. That there is something I could have done to prevent it. But there isn't. I can't help the way I feel (#5, p. 10).

Natalie, while comfortable with the label of depression, similarly experienced a certain amount of judgment and lack of understanding from people.
I didn't really tell anyone I didn't know because I felt I had to qualify it with an explanation. Even now, if I wasn’t involved in getting the word out, I wouldn’t want to talk about it. Unless you get into a lengthy explanation, people just don’t understand. That is what is so frustrating. People don’t understand. When this affects so many women, people should understand (#2, p. 25).

The application of the label postpartum depression resulted in a mixture of emotions. On the one hand, the relief of discovering a logical explanation for their experience was welcomed, however, the label itself created additional and new anxiety. As I listened to the women’s stories with respect to their response to this label or "diagnosis", there seemed to be a medicalization of the experience and the subsequent prescribing of medication. This, too, became another struggle.

All of the women in this study eventually came under the care of their family doctor and were directed to take medication for the treatment of their depression. The medication struggle became one more area of confusion for many of the women in the study. I want to stress that the purpose of the following discussion is not to determine the efficacy or appropriateness of medication, but rather to hear the stories of the women themselves as they very clearly demonstrate a colorful blend of beliefs and values with respect to this issue.

Kanelli, Vicky and Laura made a decision not to utilize antidepressants. Kanelli’s thoughts on the subject are depicted in the following quote.

My doctor gave me antidepressants and I started vomiting So, in my brain I said, "oh the pills make me vomit." Well, they probably are strong for someone's stomach and I wasn't eating. At the hospital I had to take them. Then, I stopped them with my own decision. I said, "no, I can do without." I didn't want to take pills. I didn't want to introduce myself to this world because then it is hard to come out. (#3, p. 15).

Vicky, on the other hand, entertained the idea but only because she was also suffering from insomnia and felt that the medication might alleviate the problem.

At one point, I even went to a homeopath out of desperation because I didn't want to go on medication. I really grappled with the antidepressants thing. I had a psychiatrist's appointment and she, of course, said to take antidepressants. And stop nursing and take a form of antidepressants that will act sooner than the older
ones which do allow you to breastfeed. I was not in a position to stop breastfeeding because I worked so hard to get that established. I had such a struggle with it and overcame it and I like doing it. I wasn't going to stop it. So I went around with these prescriptions for antidepressants in my purse. I never filled them (#6, p. 3).

Laura, although she did not take antidepressants, expressed a desire for a magical pill that would take the pain away. Laura's devastating experience with her doctor as described earlier with respect to help-seeking, resulted in her choosing not to utilize medication because she was told she would have to stop breast-feeding to take any kind of antidepressants. Her feelings about this experience are reflected in the following statement.

I would have been on those pills if she would have said I could breast-feed at the time because at that time when they offer you drugs you are so weak that you would do anything. When you have a headache you take something. I am not going to sit around and see if I can handle throbbing pain for hours. It is something you get rid of. It's pretty devastating knowing there was nothing to take for this. A mixture or a potion you could rub on your head and it would be over (#7, p. 11).

This whole experience had devastating consequences for Laura. Since she would not take the antidepressants, the doctor then prescribed the birth control pill; she felt that the pills would regulate Laura's menstrual cycle. However, after two months of struggling with a fussy baby, Laura went to another doctor and discovered that the birth control pills caused her milk to dry up and subsequently, the baby was not getting enough to eat.

Dawn, who went on medication, felt that it did help her to overcome her depression but talks about the confusion it created for her. She actually researched the medication and sought out second opinions prior to making the decision. The following quotes describe her dilemma.

So I went to see the doctor and told her I was postpartum depressed and she said she was going to prescribe Paxal. I said, "what is it?" And she said it was an antidepressant. And I said I wasn't taking it. And she said, "you should really seriously think about it." I said we didn't even have aspirins at home. I said I didn't really want to do this. She gave me some pills and told me to just try it and if I didn't like the way I was feeling, I could change my mind. So, I went out and bought a whole bunch of books and started reading so I could get a sense of what I was doing. The first day I went to take the pill I sort of put it in my mouth
and I thought, I guess if I lose my mind or I go crazy I guess that will have to be the consequence, um, I'm just going to have to take a leap of faith. With taking Paxal I started to feel better right away but that didn't mean I felt okay about taking it. I struggled with it the whole time I was on it, which was a year (#1, p. 26).

For Amanda, Natalie and Isla, the use of medication was an important part of their recovery. Isla used the following analogy to describe her reasons for taking antidepressants.

My doctor used the approach that if you were a diabetic and you had to take medication you would take it because it is a physical problem. Depression is, to a large extent, a physical problem. The biggest decision was making the decision to give up breastfeeding. Um, but once I got over that...I mean, living in hell is ugly. You have to do what you have to do so I didn't have a problem with taking medication (#8, p. 21).

Jennifer's experience was somewhat different in that she felt that her use of Prozac actually made things worse and resulted in her attempted suicide.

I didn't know it at the time but one of the most common side effects of Prozac is anxiety. My personal experience is that I would not recommend it to anybody. I cannot understand how a mature woman, a mature professional woman could become so dysfunctional. How can she get to the point where she would actually try to kill herself. Even now, it's like that wasn't me. But, um, I wonder, getting back to the Prozac, if the anxiety added to what I was already feeling. I was weird. My behaviours were bizarre (#4, p. 16).

The stories relayed through the words of these women speak to the complexities associated with the use of medication. The pressure and often contradictory information from the medical profession combined with the women's desperation to feel better often placed them in an ambiguous situation.

As demonstrated, the surrendering to the phenomenon of postpartum depression was not without difficulty. It was an essential step in the path to wellness. It must be recognized that this all important piece is significant in that it signals the progression towards the need to create a sense of hope which ultimately propels the women forward yet again.
The Creating of Hope

In the process of Getting to the Other Side, the creating of hope was composed of two elements: Feeling Better and I'm Not Alone. By this time, the hopelessness and the darkness was beginning to subside and these women were beginning to see the light at the end of the tunnel.

As a result of many different factors, women began feeling better. Whether it was medication, physical exercise, or getting more sleep, the experience for the women at this time was an increased physical and emotional sense of well-being. This is not to say that those times of despair did not reoccur because as I mentioned previously, this was by no means a linear process. However, the moments of hope began to outweigh the feelings of sadness, loneliness and despair.

Dawn, although ambivalent about the use of medication, uses the following metaphor to describe her feelings in relation to the immediate effects of the antidepressant.

It was like I didn't have to tread water anymore. I could touch the bottom of the pool. Now that my toes are touching the bottom of the pool I can take teeny weenie steps with my toes to get back to the shallow end (#1, p.28).

Natalie describes a similar experience when she decided to go on the medication.

And after a couple of weeks on medication it was like night and day. The cloud lifted and all of the fears and anxieties were still there as much as ever but at least I could identify them and see where they were coming from whereas before it was just like everything was raining down on me so heavily I had my hands over my head and I couldn't look up to see where they were coming from. So now I could start to identify the issues that I needed to deal with and start working through them. So I don't think I would have ever gotten anywhere without medication (#2, p.6).

Some women began to develop strategies to deal with those times when they felt that things were beginning to slide. When Kanelli got out of the hospital and made a decision not to use medication, she began to look for ways to deal with the depression.

When I came out of the hospital I said to myself that I was really going to fight it. When it hits me I will go for a walk. When it hits me I will put some music
on or I'll have a bath and fix my hair. What I did, I noticed a tremendous amount of difference when I went back to my normal cycle which was two months after the baby. I decided to go on exercising. I discovered that it helped me a lot when those moments of despair and complete, you know, darkness came into my mind. I have a stationary bicycle and I would go up and all these things were spinning around in my head and I would go stronger and stronger on my bicycle and fight this. And it cooled down a little bit and just eased it. It helped me a lot. I found out that it helped me a little bit to overcome those thoughts or the mood swings (#3, p. 13).

Amanda found that scheduling childcare for her daughter and resuming physical exercise were important factors in her process of feeling better.

I got her into this really good daycare three days a week and I was working. We sort of got into this rhythm. Once a week we'd go to the gym and she'd go to this baby-sitting service. But within a month or so I started to feel a lot better and exercise was my salvation (#5, p. 4).

Jennifer described something quite different in terms of what helped her to start feeling better. She recalled her time in the hospital as hitting rock bottom, but at the same time considered it to be a turn-around place. It was a safe place for her to be and the result was that she was able to have time to herself. She describes the hospital as the place where she was able to access all the repressed anger towards her husband and her feelings of being controlled by him.

It was the anger that propelled me. I found out that my husband was trying to get a social worker involved. To have a social worker come and look after my children! This was the best thing that could have ever happened. It was like, "r-o-o-o-o-aar! I was so angry at him. I was so angry at him and it turned me around. I went to the other extreme. I had too much energy. I remember when I was in the hospital, I would run up and down the stairs and up and down the stairs because I didn't know what to do with all the energy. It was huge. It was like an external force (#4, p. 15).

Natalie recalls feeling better when she found out that she would recover from the postpartum depression. After living with it for so long, she felt as though it would be a part of her life forever.

My psychiatrist told me that the prognosis is excellent for postpartum depression. It is a little more complicated when there is a past history of postpartum depression.
depression but as long as it is a postpartum depression or whatever you want to call it, you can get better. It doesn't have to be this way (#2, p. 28).

Laura vividly remembers her first phone call to the Pacific Post Partum Support Society and how reassuring it was to simply have someone that understood what she was feeling.

She called and talked to me and we talked for about an hour. I cried and cried and cried and cried. It was such a relief to know that she knew what I was talking about. She said that I was brave and I can't tell you how that helped...even saying it now (became very emotional). She kept saying how brave I was and these were the things that helped me to continue (#7, p. 4).

For Isla, she felt better with the simple fact that other people knew about her depression. This knowledge resulted in the provision of support and understanding from significant people in her life.

Knowing that other people knew about it. Knowing that if other people knew about it, they wouldn't let me get worse. My doctor was incredibly good. The fact that she wanted me in her office every two weeks. It was enough that somebody gives a damn about me (#8, 2nd interview, p. 2).

As described by the women themselves, a combination of different things helped them to start feeling better and regaining a sense of hope. An additional part to this creation of hope had to do with the development of a support system and the realization that they were not the only mothers feeling this way.

A common thread for all the women in this study was the realization that they were not alone in this process and this too became a piece of the creation of hope in their lives. I am not alone was voiced repeatedly in the stories of these women. As mentioned previously, attendance to the Pacific Post Partum Society support groups was part of the help-seeking process for the majority of the women in this study and played an integral part in the creation of hope in the lives of these women.

As the feelings expressed by the women with respect to their experiences with the group process were very similar, I have chosen a series of quotes from Laura, Vicky, Kanelli, Dawn, Amanda and Isla that I felt expresses their sentiments.
The group helped me so much. It helped me just listening to other people and seeing where my own recovery was. The first day I went there, there were three people leaving and I thought, "how can they leave? how can anybody leave?" I am doomed to be here forever. When I got to the middle and I saw the people that came in I thought, "I used to look like that...so sad and desperate, you know. And then I'd look at the people ahead of me and it was "why are they smiling?" And when I got to the end I must have drove people crazy because I was really happy knowing it was almost over. That was great. I thought about being in a group of people and telling everything would be hard but it was easy (#7, p. 5).

I think it was getting out and doing something to help myself and talking to other women in a similar situation and share stories and hear stories and hear connections (#6, p. 15).

First I found out other women had the same problems as me. Secondly, it was a cozy environment to talk with other women. Like, a secret nobody knew about. I found that when I was walking away from here, I was all cheerful. I remember after that first night, I went back home to my husband, "I have to go there." It really felt good. So many similar feelings. You feel you are not alone. You are not the only one who has problems with their husband. There are other women who are struggling (#3, p. 14).

The intimacy amongst the women was so profound to me. How a group of women who were so different yet were so much the same in their experience of motherhood. Every week I felt support, listened to, normal and I could go away feeling I was closer to getting better because people do leave this program (#1, p. 27 & 30).

Having met all these other women makes you realize that you are not the only one in the entire world going through this. Having found all this emotional support has been a godsend (#5, p. 15).

Every time you would hear someone talk, you could relate to something that they said. It may not be exactly the same but you could interpret the feelings. It took me a long time to say good-bye to that group (#8, p. 18).

Jennifer's experience with the group was somewhat different in that she had attended the group early in her depression but did not continue for any length of time. She, however, began seeing a counsellor that played an integral role in her own recovery process. It is abundantly clear that the ability of a postpartum support group to provide a safe environment where women could share their innermost thoughts and feelings was invaluable. It became a place where the women discovered that they were not alone and
that the expression of those frightening and dark thoughts would not be judged or criticized. It also became a place where women were able to learn about more about themselves and the subsequent journey to recovery.

**Rebuilding the Self**

As the women shared the last piece of their stories with me, I noticed pride and strength in their voice as they triumphantly acknowledged and described the process that led them to a stronger sense of self. Rebuilding the self was a phrase expressed by Dawn in that she felt that the monumental changes and growth that occurred for her during this ordeal resulted in a rebuilding of self as opposed to the phrase I initially used, reclaiming the self. The rebuilding of self can best be viewed as the questioning process that these women have gone through and the movement to greater clarity with respect to their expectations and needs. Earlier in the process expectations and needs were blended; the boundaries between the two were blurred. However, they are now beginning to separate as women become clearer about setting limits and boundaries and recognizing their own needs and getting those needs met on a daily basis. The elements that speak to this property of Rebuilding the Self include: adjusting expectations, recognizing and meeting needs, and coming to terms.

**Adjusting expectations** was acknowledged by a number of women as a means by which they became free from the constraints imposed on them not only by others but by themselves as well. These adjustments in expectations included shifting ideas and beliefs with respect to themselves as mother, their partners and family members.

Dawn felt that her expectations of herself to be strong and self-reliant and subsequent inability to seek help played an integral part in her depression. Her perceptions were that people should know what she needed yet the image she presented to others sent a clear message that she was managing well with the transition to motherhood. In reality, this was not the case. Dawn shared her innermost thoughts in the following quote.
We're raised in families that think we need to stand alone and do your own thing yet that is not a healthy way to be. I think, for me anyways, I expected people to take care of me because they should know what I needed but nobody ever saw me as needing anything because I never behaved in that way. So no one asked and even if they did ask, I would have said no because I'm not supposed to. I mean there was this real terror and it wasn't until I could see myself ask, a strong healthy person is a person that asks for help, not one who says keep a stiff upper lip. That is an isolated person. That is not an interdependent person. So I had to change my expectations and my perceptions in order to get that. When I could shift my perceptions, then I could see the need clearly and it is still hard for me to ask for help because what I have had drilled into me is that you don't need anything, you are just a self-sufficient island unto yourself (#1, 2nd int. p. 25).

Likewise, Vicky also spoke to adjusting her expectations with respect to living for the moment rather than always worrying about the future.

I really didn't live for the moment. I would always be looking forward. Like going to see my parents. That was one of those things where I just wanted the future to come faster. The closer it came the more I wanted to be there and so the anxiety level went up. But I don't seem to do that so much anymore. It must have to do with the whole process of coming through this. And, um, just realizing that something is not going to last forever even though it feels like it is at the time. Trying not to have expectations of things. If you live too much in the future you start to expect a lot and then the reality sets in and you are disappointed. (#6, p. 13).

Often the adjusting of expectations had to do with the women's perceptions of their own worth as a mother and their contribution to the family. Laura spoke to the adjustment of her expectations of herself as well as of her children.

You'd have some pretty neurotic kids if you keep the same expectations you had when you were footloose and fancy-free and had all the time in the world. A lot of the times I just keep telling myself, "it's okay if they want to play with playdough and it gets stuck to my shoe. That is okay. There are certain places I don't want them to be such as in the dining room but other than that it is a free house. I used to get stressed out about sickness too but now it is the same thing. My whole attitude has changed. If the kids get sick, then I'll just wash my hands a little bit more and make sure I don't get sick. I am not worried. My children will get sick. It used to drive me nuts (#7, p. 16).

Amanda also reflected on her changing perceptions of herself as "needing to do it all."

Realizing I am not superwoman. I must have said that to my husband a hundred
times in the past six months. There's been a couple of times that he has made
comments about my cooking and stuff. And I just say that I am not superwoman.
I have to look after the kids. I have to look after myself (#5, p. 19).

Amanda and Natalie both described the realization that it often became necessary
to take a serious look at their expectations of support of the people in their lives. Amanda
spoke to adjusting her expectations with respect to family, and in particular, her mother-
in-law.

It took me a long time to come to peace with that about my mother-in-law. She
just doesn't want to hear the bad stuff. It's just not in her to listen to that. So,
now I know that. Like I'm at peace with my relationship with her. I know what I
can get from her and what I can't. But that was my big struggle too. I wanted this
surrogate mother and she just wasn't it (#5, p. 12).

Natalie, on the other hand, spoke about shifting her expectations with respect to her
husband. She found that she was looking to him for a certain type of support that he
simply was unable to give her. As a result it became a source of anger and frustration for
her until she was able to look at things differently.

My husband just doesn't get it. I don't think men could. That is something I have
really learned through this experience, the difference between men and women and
how much women need other women. All these women are leaning on their
husbands for the support they should be getting from women. And the men are
just out in left field. They don't know what we are talking about and they
shouldn't have to know what we are talking about. As I said, once I let go of the
unrealistic expectations from my husband, I was much happier (#2. p. 23 & 30).

Before these women could become well, the expectations developed and
articulated before the birth and during the early days of motherhood had to be re-
examined openly and honestly such that the realities apparent could be recognized and
utilized to form more realistic and manageable expectations with respect to self and
others. The myths of motherhood were portrayed repeatedly in the stories of these
women; the inherent love of motherhood, doing it all, the perfect mother and so forth.
Once the women in this study were able to begin questioning and challenging these myths
and readjusting their expectations, they were able to move forward and begin to access
their own wants and desires.
Recognizing and meeting needs was a necessary step in the healing process for all of the women in this study. Again, I must stress the importance of recognizing the interplay back and forth between adjusting expectations and recognizing and meeting needs. As mentioned previously, for many of the women, part of this shift for them was directly related to their participation in the support groups of the Pacific Post Partum Support Society. Self-care was a strong component of the group process and proved to be a successful and integral part of the rebuilding of the self. The women's stories indicated two parts to this process: recognizing they had a right to getting their needs met and then designing their own prescription to continue the path to wellness.

As described earlier in the findings with respect to expectations of self as a mother, women often described their belief that mothers must be self-sacrificing for their children. In the following three quotes, Dawn describes her process of recognizing that mother have a right to meet their own needs and the realization that asking for and accepting help were part of the process of getting her needs met.

I finished the group in July. The things that came from the group, the biggest thing was self-care and how do I take care of myself. And again, I had no life experience with that because I had a non-nurturing and emotionally unavailable mother. So I didn't know how to do that. I had no role model for how to take care of myself. So I began to realize that this was about taking care of me. But it was also about reaching out and asking for help which is still hard for me to do (#1, p. 29).

Given the reality, what do I need to do to take care of myself because the bottom myself and part of it might be about that I need to phone friends. I need to talk to someone who can empathize with me and just say you are okay, you will be all right (#1, p. 33).

I think a mother often begins to believe she is indispensable. And I think a lot of us create that for ourselves. That we are indispensable and therefore, nobody else can do it. Um, and I guess being able to understand that a child has needs and that yes, you have needs too and if you can take care of your own needs then it is easier for the mother to let the baby be who the baby needs to be (#1, p. 42).
Jennifer also struggled with the inability to ask for help and recalls being taught this skill by a counselor she was seeing after she got out of the hospital.

With this counsellor he taught me how to ask for help. He said it was okay to pick up a phone and come in and talk to him. That was really significant. So I knew I had to pick up the phone and ask for help (#4, p. 24).

Amanda also experienced great turmoil when it came to asking for and accepting help from others. She felt obligated to reciprocate all offers of help and guilt would set in if she was unable to follow through. As a result, this became a source of stress for her. However, she describes the following dramatic change.

So, it's just like all this self-talk to myself, "if someone is going to offer help then just take it." But I couldn't do that before. I'd say, "no, it's okay because I'd feel guilty or whatever. And I still do that sometimes. But at least I know that and I'm trying to work on it (#5, p. 19).

Similarly, Isla has made huge strides in her ability to ask for help and the realization that she does not have to do it all on her own.

I am allowed to ask for help or I am allowed to want to do this and in order for me to do this I need to ask for help. I need you to get the kids out of here. And he knows the only way I can do anything in this house it to physically remove the kids or at least get them downstairs. I'll ask for anything now. The moment I am hit with a project I start delegating. Instant reaction. I am not going to do this myself. I don't have to do this myself (#8, p. 20).

Kanelli also talked about her realization that she had a right to look after herself.

I am the person who taught me the word "me." What is convenient for me. I used to give people a lot. That is what I did for my husband. That is why our relationship was rotten. I gave, gave, gave. So he says, "she give." Now he says, "she does not give." I had to go through this to smarten up. Here I am, smarter. I know how to take care of myself. I know how to please myself! (#3, p. 24 &26).

Laura felt that it was important for her to let people know that she wanted recognition for the work that she was accomplishing in the home as a wife and mother. This was a huge shift for her as is described in the following quote.

I remember coming home and telling my husband that I was really sad and that
I didn't feel like he appreciated me. He was flabbergasted. He'd never heard this before. He thought I'd lost my mind. He said, "but this is your job." It's more than that. "My job is all day and your job goes from here to here. And we need to share the responsibilities facing us." Stay-at-home moms really do stay at home all day and what happens if you start taking care of everybody even your husband and that is not supposed to happen. So in the end, I just felt like "nobody takes me for granted anymore and I know what I do and sometimes I have to remind him. Whereas in the beginning, I felt I had no place in the family, no purpose of being (#7, p. 6).

Natalie, who had postpartum depression with her first child, talked about how she learned the importance of taking care of herself and how this directly relates to her ability to care for her two children.

I don't need to be beat over the head twice. I learned my lesson the first time. I need to take care of myself and recognize that I need to take care of myself. If I don't take care of myself then I cannot take care of my kids (#2, p. 8)

The ability to recognize their needs and determine ways of getting those needs met in a meaningful and significant way was articulated clearly by all of the women in this study. Each and every one of them were able to describe this area of growth as a means by which they began to regain control in their lives and move past the dark times associated with depression after childbirth.

Coming to terms with depression after childbirth might be likened to the fitting of the final piece to the puzzle. Coming to terms with such a frightening and devastating experience is not easy, however, and this is still an area that many women are struggling with today. Although they have come through an incredibly difficult time, the experience has left many scars and the following stories of how women have come to deal with those scars provide a multitude of perspectives on this issue.

For some women, the fact that they survived such an incredible ordeal became a source of strength for them and they were able to use that experience as a means by which to identify their own growth and learning. The following quote by Kanelli was very moving.

All of these things have brought me to a very mature stage of my life. You always get something good from something bad. So right at this point, I should not
regret it. It was a tremendous ordeal. I don't want any woman to have it. I really hate the idea of any woman going through that. It is an ordeal. It was like an inferno. But I went through it and I survived it and it probably has left some marks on me. I better be stronger. I better be wiser. Because I went through it and I survived it (#3, p. 16).

Similarly, the following quote by Laura speaks to the same issue:

I am a different person. Much stronger. I don't know how you could be the same person because so many things happen to make it different. I have nothing negative to say about it. Going through it was really terrible and I don't wish it upon anyone. I have nothing negative to say about what happened. I have the same family and a better understanding of myself. Wiser. Much more patient (#7, p. 21).

Isla feels that she has learned a great deal from her experience and she has integrated this learning into her life.

Now I know what relaxation is. Relaxation is when you stop thinking and enjoy the moment. I can do that now. I couldn't do that then. I still had the overwhelming feeling. It was panic. I am not allowed to do this. I should be doing. So now I guess I am learning how to relax and giving myself permission. I am a much stronger person. I have much more self-knowledge (#8, p. 19 & 21).

Amanda and Jennifer both talked about how their self-esteem was affected so badly during the depression and this is one of the areas that is slowly beginning to change for them. Jennifer described her self-esteem as being in sub-zero temperature and seriously questioned her own parenting abilities. She now looks at things much differently.

I thought I was doing a horrible job and now I think I was doing an above average job but at the time your perspectives are clouded (#4, p. 14).

Similarly, Amanda said the following.

I still see myself doing things I don't like but it is learning to accept the fact that I will have bad days and I know I'm not the only one that often feels like they hate their kids. Getting to know a part of yourself you did not know before. Maybe I am not the mother I thought I would be but I am doing my best (#5, 2nd interview, p. 4).
For these women, another issue with respect to coming to terms with postpartum depression is the loss experienced around the relationship with their child or children during that time. This is still painful for many of the women. Dawn tearfully shared her feelings around this matter:

I didn't bond with Jesse, so there was confusion there. I hear women say, "it's like falling in love, but I never had that. I am forty years old and I have been through all this shit and abuse and yet, somehow through all of this I've still been able to give him something. I guess that is good. So as hard as that has been and as much as I feel that I am not capable and I don't know how to do this, I am finding someway to at least, I mean I love him and I tell him I love him. There are lots of things I don't do and I've been working on that, but he is all right. He's all right (#1, 2nd interview, p. 9).

Kanelli also experienced this feeling of loss around her relationship with her child.

I believe that the connection was split like we didn't have that beautiful relationship. Unfortunately, with my first son, I still try to mend that gap which was done in those days when I was working and I was depressed (#3, p. 10).

Isla recalls her negative feelings about her child and how she is still dealing with the guilt feelings associated with this matter.

I hated my child. She was about the two year marker when I came close to even liking her. That is a really horrible thought. But it is true. It is a horrible thought to have to live with that. For the first two years I didn't know what my problem was and I looked for anything to put the blame on. What is the mother-child bonding process? I can't even stand her. Maybe that is why she is such a cling-on now because she knew there was something wrong. So, of course the guilt lays in (#8, p. 8).

Some women have regrets about their poor relationship with the baby and worry about the long-term effects on the child. However, they have been able to maintain their perspective and are finding ways to overcome those feelings and mend the relationship with their child.

Despite the fact that the women in the study feel that they have come to terms with the experience of depression after childbirth, some were very candid in their expressions of fear of the depression returning or of having another baby. Dawn worries
about the reoccurrence of depression and works very hard to be sure that the necessary coping skills are in place.

For me, things shift more quickly if I change my doing, my physical behaviour as opposed to my thinking. Then I can shift my thinking by changing my doing. When I feel myself, "this isn't a good day", then I know I need to get to the gym, and go for a walk. I need to figure out what I need to do today to get balanced cause it is going to be a hard day (#1, p. 37).

Isla also describes the means by which she deals with the difficult days.

What I have learned is to recognize the signs. The minute I start clock-watching it is time to take care of myself. When I feel resentful, it is time to start communicating and when I feel overwhelmed I know it is time to ask for help. So I am not afraid of going off the medication because I have some coping skills and I have recognition (#8, p. 22).

Kanelli also fears the return of her depression and she describes the inner conflict she often experiences

I don't want to lose myself again because then I will have nothing to give my children. I want to give them the good part of myself. I don't want to go back to depression. I want to stay with myself. I want to be happy. I don't want to be a gloomy mother. One who is crying and then when they grow up you say to them, "I sacrificed my life for you." No, I don't want that (#3, p. 24 & 31).

For women who have been through such a devastating experience, it is certainly not unexpected that such fears would exist. Fortunately, the women in this study have developed an extensive set of coping skills that they would not hesitate to utilize should the warning signs commence.

In conclusion, the women in this study portrayed depression after childbirth and the subsequent path to recovery as a journey. Although the journey itself was unique for each of the women, the goal was the same. To make sense of their experiences in terms that they could understand, to formulate adjustments in their initial expectations, to begin recognizing their own needs despite the imposing realities associated with motherhood and finally, coming to terms with the experience of postpartum depression. While each woman in this study relayed a unique and convoluted personal path the analysis of the
data, upon closer inspection, yielded the significantly similar stages of Why Did This Happen?, Spiralling Downwards and Getting to the Other Side.
Chapter Six
Discussion and Implications

In this chapter, I will discuss the research findings with respect to the existing literature, implications for practice and policy and implications for further research. Lastly, the limitations of this study will be examined.

Existing Literature

A study of this nature becomes most valuable when it is contrasted to existing literature and an attempt is made to integrate the study with the larger existing pool of knowledge. For a study to simply stand alone and not become synthesized with mainstream thinking is to leave the task incomplete. The current literature on postpartum depression can be divided into three main streams: research literature, theoretical literature and popular literature. These three areas will be explored as they relate to the particular findings that have emerged from my study in an attempt to discuss how my findings support, add to and refute the existing literature.

This study was designed to gain insight and develop new knowledge about depression after childbirth by listening to the accounts of the women themselves. Eight women who had recovered from postpartum depression reflected back on their experiences and told their respective stories as to how they made sense of that time in their lives. In this respect, this study was unique in its attempt to provide women an opportunity to discuss their whole experience. Most studies have focused on interviewing women who were in the midst of a depression as opposed to those women who had recovered. As mentioned earlier, some of my ideas for the questions in my interview guide were based on the work of Brown et al. (1994). Their study is the only other study I could find that utilized this perspective.

The findings in this study are consistent with the feminist theoretical literature on motherhood and postpartum depression (Oakley, 1980; Rosenberg, 1987; Rossiter, 1988;
Field, 1989; Knight, 1992; Jebali, 1993; Mauthner, 1993). Throughout the course of this study, it became evident that the women's experiences with depression after childbirth were directly related to the stresses and strains associated with the transition to motherhood and the contradictions inherent in the myths of motherhood. That is to say, the good mother is self-sacrificing, nurturing and provides selfless devotion to her family and accepts this as her greatest source of happiness. The myth of the good mother speaks to a series of expectations that are internalized by women. The findings in my study indicated that when the increasing dissonance between expectation and reality became too great, women became overwhelmed and disillusioned with the new role. The struggle to integrate the role of mother into a woman's life is a complex process and for many, it becomes debilitating as the dominant ideology of motherhood bombards them. This quote by Block (1990) speaks to this issue.

Imperfect creatures in an imperfect world, we dream of gods and goddesses and paradise and conjure up images of perfection; the ideal mother who is always patient, the ideal woman who is always passionate, the ideal person who is always creative, and the ideal family whose members are always loving. These "phantoms" inspire us to transcend our limitations (they are strong where we are weak), seduce us into believing that we can do the impossible (they know no boundaries, while we are made of flesh and blood), and torment us when we are forced to admit that we are indeed flawed (p. 149).

The transition to motherhood can be viewed as an evolutionary process. Adapting to the new environment of motherhood can be a very difficult and challenging process for all women. Rossiter (1988) suggests that women live in silent despair that comes from trying to respond to the contradictory statements about mothering (p. 270). The ideology of motherhood contributes to the construction of a series of expectations that women carry with respect to the birth, themselves as mothers, and the people in their lives. Generally, these expectations do not match the reality of what actually occurs and the probability of disillusionment and disappointment is inevitable.
The ideology of motherhood that is shaped and constructed by our society plays an integral role with respect to the expectations placed on women as mothers. The myths of motherhood are portrayed repeatedly in the stories of the women in this study; the inherent love of motherhood, the perfect mother, the superwoman and so forth. However, they did not always see a relationship between the expectations of themselves as mothers and the development of postpartum depression. The majority of the women in this study viewed their postpartum depression as an illness and took comfort in the diagnosis as such. The feminist theoretical and research literature, however, have challenged this issue of medicalizing women's distress (Nicolson, 1990; Ussher, 1992; Brown et al., 1994).

The women in the study saw things from a different perspective. They felt that naming their postpartum depression as an illness freed them from self-blame. However, to some extent, there remains an individualizing of the problem because the larger social context of the mothering role is not recognized to be a problem. I believe it is essential to transcend the medicalization of their distress and begin to challenge the societal construction of mothering in order to free women from their restraints and the oppressive nature of motherhood. Women often do not see this aspect of motherhood because once again, the underlying assumption of motherhood is that it is unacceptable to have such feelings. The following quote by Finch (1984) provides a perspective on this issue.

I found that I had to look more closely at the structural position in which these women were placed, and to make a clear distinction between structural position and the women's own experience of it. This enabled me to see that evidence of women successfully accommodating to various structural features of their lives in no way alters the essentially exploitative character of the structures in which they are located (p. 84).

Very often, the single expectation of being the perfect mother negates that same individual from seeking assistance from others. To seek assistance would be to admit or
show that a very important expectation of being a perfect mother is not a reality. Block (1990) captures this well in the following quote.

There was never any question of conflict between a woman's needs as a person and her role as a mother, because ministering to the needs of others was considered an expression of the female character. A women "naturally found fulfillment in cultivating the potentialities of her children (p. 156)."

At the same time, because women feel that they must portray the image of the perfect mother, those around them see a competent and able person who does not require support or assistance. My findings with respect to women's inability to define their own needs and subsequent inability to have those needs met was a significant occurrence that is not currently acknowledged in the research literature. However, the most current popular literature (Dunnewold & Sanford, 1994; Kleiman & Raskin, 1994; Placksin, 1994) does make recommendations to new mothers with respect to self-care.

As the women in this study attempted to make sense of why they experienced postpartum depression, it became evident that is a complicated and convoluted issue and the women, themselves, alluded to this by making statements such as multi-faceted, a mish-mash of things and there is no simple answer. This is certainly concurrent with the existing body of literature on postpartum depression. In the context of motherhood, many things are happening at the same time. To compartmentalize the difficulties associated with motherhood is to suggest there is an orderly way of coping with the overwhelming aspects of motherhood. Brown et al. (1994) state that each of the separate parts that make up motherhood contribute to the whole emotional flavour of the experience (p. 201). Thus, understanding the complexities of the context within which women experience postpartum depression is essential to gaining insight to the larger picture. The individual experiences of a woman's situation must be taken into consideration in order to adequately understand why there is a shift from the adjustments associated with motherhood to a debilitating depression.
Although the research findings were contradictory with respect to negative birth experience, many of the women in this study clearly felt that the events surrounding the birth of their child was a factor in their own depression. Kendall-Tackett (1993) suggests that a possible explanation for these contradictions is that the focus of these past studies was on objective complications or circumstances of birth rather than on the women's subjective reactions to these events. In other words, as long as the baby is healthy and safe, then women are supposed to feel happy after the birth despite any trauma that may have occurred during the delivery.

Physical exhaustion due to lack of sleep or inability to sleep are two areas that are relatively unexplored in the literature on postpartum depression. In this study, all of the women were affected by sleep deprivation and they clearly identified this issue as a factor in the onset of their depression.

In the research literature, lack of support and poor relationship with a partner have been identified as predictors of postpartum depression. The findings in my study concur with previous studies. Lack of emotional and practical support from partners, family and friends and relationship problems are common themes that appeared to play an integral part in the onset of depression.

This is also related to the work of Stern and Kruckman (1983) and their suggestion that our society lacks recognition of the significance of the postpartum period. The postpartum period should be recognized as a time distinct from normal life, a time when a woman is to recuperate and to receive nurturing and support from her social support system. The lack of social structuring of the postpartum period was expressed by the women in this study. Many felt a profound sense of loss and rejection by their families and their health care practitioners. They felt that they received very little acknowledgment with respect to the physical and emotional changes associated with giving birth.
Stressful life events and stress associated with infant care were identified by the women as possible factors contributing to the onset of depression. These findings also concur with the research findings in the existing literature.

The research findings with respect to personality factors have been contradictory, yet many of the women in this study felt that their desire to be "perfect" and their need to be in "control" may have contributed to their depression. Again, these characteristics may well have played a part in the onset of depression, but it is essential to look beyond individual deficiency and question where these expectations of perfection and control originated.

A previous depression and a history of family depression and poor relationship with mothers, although inconclusive in research literature, were identified by the women in this study as contributing factors to their postpartum depression. In particular, unresolved issues with mothers were a common theme with the majority of the participants.

Themes of loss were also significant in my findings. Loss of identity, loss of freedom, loss of life the way it used to be and so forth were identified by many of the women in this study as contributing factors to the onset of depression. This is concurrent with the work of Nicolson (1990) and Watson Driscoll (1990) who both suggest that postpartum depression should be likened to that of a grieving process as opposed to an illness.

The inconclusive findings with respect to hormonal changes as a cause for postpartum depression was concurrent with my own findings. Some of the women were convinced that hormones played an integral part in the onset of depression while others were adamant that numerous other factors were at play. My study was not designed to disprove hormonal causes but went as far as to consistently demonstrate that the medical model is not sufficient to explain or treat postpartum depression.

The shift to "spiralling downward" was not a clear shift by any means and many of the women described themselves as moving beyond the realm of "typical adjustment."

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Beck (1992, 1993) found themes of loss of control, isolating oneself, contemplation of self-destruction and loss of self which were similar to the findings in my study. Due to the recurring theme of lack of support, I would suggest that it is highly likely that this factor could play an integral role in preventing the downward spiral into depression. This was also suggested by Chalmers and Chalmers (1986) and Kendall-Tackett (1993).

With respect to recovery from postpartum depression, there is very little in the literature that specifically speaks to women's own accounts of their recovery process. MacIntosh (1993) did look at women's help-seeking behaviours and showed how women's perceptions of their depression had important implications for seeking assistance. In his sample, he found that the majority of sufferers did not seek assistance for their depression from any source until the depression became debilitating. My study indicated similar findings whereby some women were depressed for more than two years before seeking help.

The current trend in the research, theoretical and popular literature with respect to postpartum depression is focusing more and more on prevention and treatment (Holden et al. 1989; Elliott, 1989; Abriola, 1990; Gruen, 1993; Stuart & O'Hara, 1995). Psychotherapy, group therapy and self-help groups are examples of recommended treatments for postpartum depression. The value of self-help groups and the significance of support from other women are consistent with the findings in this study. Seven of the women in my study attended the support groups offered by the Pacific Post Partum Support Society. The self-help groups of this agency offer a treatment model that is based on the guiding principle that women themselves are the experts on postpartum depression. This model is useful to postpartum depressed women because it encourages talking, in confidence, to other women who have experienced the same difficulties. The women in this study felt that their participation in these groups was central to their recovery process.
The information provided by the women in this study about their experiences with depression after childbirth provides tremendous insights with respect to the difficulties associated with adapting to motherhood. Additionally, they have provided a wealth of knowledge about the actual experience of their depression and their struggles to recover from the despair.

This knowledge and expertise must be recognized and incorporated into the practice of health care practitioners. At this point, I would like to discuss a series of recommendations to new mothers and to mothers who may be experiencing postpartum depression and to those health care professionals working with these women. These implications for practice represent the views of myself and the views of the women who participated in this study.

**Implications for Practice and Policy**

Both myself and the women in this study believe that there should be interventions occurring in the early stages of motherhood that could, in fact, prevent the likelihood of the onset of the range of emotional reactions after childbirth. In other words, what types of interventions can be provided to new mothers that may prevent or mitigate the process of spiralling downward? These women have clearly articulated some key factors that they felt may have contributed to their depression. Practitioners can utilize this information to become more educated with respect to providing adequate and comprehensive services to new mothers, assessing those women who may be at risk for depression and providing a holistic approach to the actual treatment of postpartum depression.

Parenting groups for expectant parents and new parents are one avenue in which to begin deconstructing the myths of motherhood while also serving to educate couples about the potential for postpartum depression. Elliott (1988) conducted a study whereby she developed a parenting group in pregnancy as an intervention for reducing the prevalence of postpartum depression. The program was successful in engaging first-time mothers and in reducing the prevalence of depression in new mothers. In my own review
of the literature, I found very little with respect to parent education programs in pregnancy; only two (Webb, 1985; Aranoff & Lewis, 1979). Aranoff and Lewis (1979) and Webb (1985) described the development of groups with respect to issues associated with the transition to parenthood; however, they did not provide an educational component about postpartum depression. Ideally, a group that would encompass all aspects associated with the adjustment to motherhood would be the most effective. Expectant parent groups would provide men and women with the opportunity to explore expectations associated with the parenting roles, to discuss the realities of integrating a baby into their lives, to gain insight about the role of both parents in the raising of a child and to begin exploring ways of parenting that recognizes the work and value associated with childrearing.

In Western cultures, women and their families receive little or no preparation for the postpartum period, as all attention is focused on preparing them for labour and delivery (Kendall-Tackett, 1993, p. 126). Amanda expressed exactly these sentiments and advocated for the need to place less emphasis on the labor and delivery and focus on the changes associated with becoming a parent.

We should be talking about the realities of motherhood rather than putting on a happy face. This is real life. Let's look at the expectations. We can't build up false expectations. Maybe in pre-natal classes, there should be less emphasis on the perfect, smooth birth and less emphasis on birth plans (#2, second interview).

Additionally, an exploration of role changes and the expectations of partners would provide an opportunity to question the deeply ingrained socialization patterns of the roles of mothers and fathers. Men also need to understand that they are not simply "helpers" or "baby-sitters" and instead need to develop strategies for sharing responsibility so that the all-knowing mother does not attempt to perform all tasks. Subsequently, new mothers will have to deal with feelings of inadequacy and guilt if they cannot attain these expectations. Men must also be given the opportunity to accept more responsibility to
gain confidence in their ability to father their children. All of these issues should be integrated into existing prenatal programs.

Likewise, it is also essential to educate health care professionals about postpartum depression. Many professionals know very little about postpartum depression or if they do, dread informing pregnant women about the possibility of this phenomenon for fear of worrying them. As a result, women and their families are often uninformed about postpartum depression. Thus, the symptoms of postpartum emotional problems can be very frightening for new parents and the tendency may be to minimize, hide or ignore symptoms or to simply wait for them to pass on their own. New parents need to be educated and equipped with knowledge that postpartum depression is a common occurrence, that it is not indicative of personal inadequacy as a parent, and that it is nothing to be ashamed of. The stigma associated with postpartum depression can further devastate women in their roles as mothers. A more useful and beneficial interpretation of the depression experienced by new mothers would be to accept the occurrence as normal, hence mothers would be seek assistance without shame. Nicolson (1990) stresses the following

It is important for health care practitioners to help women develop a new understanding of their place in the world after such a dramatic upheaval. Mothers will need to re-establish a sense of continuity after the disruption, and only through the help in grieving for their past and help in anticipating future changes will individuals be able to adapt effectively. This means facing up to the possibility of depression as a normal and healthy grief reaction, which, given conducive support, will enable a successful transition to motherhood (p. 694).

Health care professional must also be aware of the fact that women experiencing postpartum depression may have a very difficult time expressing their feelings. Again, this is related to the idealization of motherhood and the myth that becoming a mother is equated with happiness. Health care professionals must help women to dispel the myths of motherhood and give women permission to share both the positive and negative feelings associated with motherhood.
Some of the women in this study had absolutely no idea that there was such a thing as postpartum depression and as a result, suffered in silence for more than two years. This should not be happening in our society. Postpartum depression is one of the most treatable and curable forms of depression (Gruen, 1988, p. 3) and early intervention can prevent it from becoming a crisis.

These issues are all worth consideration. The bottom line is that it is essential that these messages be integrated into existing health care services provided to new mothers and their families so that they may obtain the necessary support and treatment. Jennifer stated the following.

Talk about it in the prenatal classes. Give them handouts. I've often thought about prenatal classes but would they listen? (#4, second interview).

Kanelli said the following with respect to her own experience.

I would tell professionals to inform pregnant women that this could happen because I had no idea about it. Doctors should have an information pamphlet, like they way they have about babies. They should tell you that there could be complications. (#3, 2nd interview).

The women in this study clearly articulated their position in regards to the lack of support in our society for new mothers. Many of the women felt that new mothers are subject to isolation upon the birth of their babies. Natalie expressed her views on this matter as such.

We are so isolated in our own little corners. A woman should never go home to an empty house with a new baby and her husband goes back to work the next day. It is so irresponsible of our society to allow this to happen. Right now you get at least one visit from a health nurse and it is supposed to be within the first twenty-four hours. There should be something set up that is available for every woman regardless of how much support she has at home. Then it is up to the women to decide if she needs to use all of what she is entitled to. There must be people out there who would love to be employed as a homecare worker and just go and spend a week with new moms. How much would you have to pay? Way less than keeping women in the hospital. And you don't need professional health care providers to hand you a pillow or play with your two year old. It doesn't have to be a registered nurse (#2, p. 32).
Lack of support as a predictor of the onset of depression is evidenced in the current literature and this is certainly supported by the experiences of the women in this study. In an ideal world, women would receive adequate support throughout the postpartum period and beyond. The early discharge programs in many hospitals requires that women leave the hospital within two days or less after the birth of the baby. Previously, women often remained in the hospital for up to five days where they received education and support from nurses to help them with the physical care of the baby. Pitman (1994) states that the early discharge programs from hospitals require that women are sent home within two days and subsequently, women are cast into the privacy of the household often with little or no support. Having a baby is not an illness and maybe a hospital is not the place for a new mother to be; however, unless practical assistance and support are available to women upon their arrival home from the hospital, the overwhelming and exhausting task of caring for this tiny infant can place women at risk for depression. Again, this is an indication of a lack of structuring and recognition of the postpartum period and this lends support to the work of Stern and Kruckman (1983) who described how many countries offer practical assistance and support while women recover from birth and learn how to be mothers. Women do not have an apprentice period and are expected to fully function as mothers by the time they leave the hospital. It is no wonder that the instantaneous gift of motherhood can be such a frightening experience for women. Early discharge programs are a reality in many communities, therefore, there needs to be comprehensive support services for new mothers and their families to assist them with their adjustment to parenthood and potentially reduce the risk of postpartum depression.

Many of the women in the study had practical recommendations for professionals with respect to assessing for risk. There seemed to be some common experiences with practitioners with respect to attention being given to the physical needs of the women and their babies while the emotional aspects were not acknowledged. Natalie states her opinion about this matter.
You go for your six week check-up and they feel your uterus and as long as everything is where it is supposed to be from your neck down then you are fine. But, um, women should absolutely be screened for postpartum depression at least at the six week check-up. At least. But, it's not. Even my doctor who is an enlightened doctor, I've had to tell her everything about this postpartum depression. When they bring their children back for their immunizations, I mean, since you are going to the doctor anyway at two months, four months and six so they could be checked then and again in a year. I mean, it would only take five minutes (#2, p. 27).

Dawn also spoke to this issue, however, she suggested some specific questions that practitioners should be asking women.

They need to know the right kinds of questions to ask and to get beyond, "how are you feeling?" Fine. How are you really feeling? There are scales out there that look at those things and question beyond how are you feeling. How is your relationship with your partner? Are you sleeping? I think if somebody had asked me those questions then I would have had some awareness about whether they fell into the normal column or whether they didn't and if they were not, then I would have known a whole lot sooner that I wasn't getting enough sleep and the repercussions of not getting enough sleep would be this (#1, p. 47).

Kanelli also spoke to this issue.

I definitely want doctors to warn women especially those at risk. Immigrant women. So the doctor should be asking those questions during the pregnancy. What kind of support do you have? How is your family life? (#3, second interview).

Jennifer provided the following recommendations.

There needs to be a questionnaire or something. Perhaps there should be a three-month and six-month check-up like the babies immunizations. For the mother, there should be a check-up. They could ask questions such as how do you see yourself getting through the next 24 hours?, what are you doing well?, what are you not doing well?, and what would you like to see different? Specific questions related to finances, relationship with your partner, and how much sleep you are getting should also be asked (#4, second interview).

Isla discussed the need to practitioners to be knowledgeable and educated about postpartum depression in order to adequately assess risk.

My full belief is that someone needs to be in there at three months. Somebody with an objective but knowledgeable point of view needs to be in every woman's
life. If they are knowledgeable, they would slide in some questions but they have to be educated and knowledgeable and know what the signs and symptoms are (#8, second interview).

Often, women may feel embarrassed to talk about how they are feeling or may minimize their feelings. Vicky also felt that her doctor did not ask her specific questions.

I went to my doctor for my six-week check-up and I had been up and down and up and down but I never talked to her. The woman may feel that there is nothing wrong or it is just postpartum adjustment. My doctor wouldn't have known from what I had said. I think it might be hard for them to recognize unless she would have asked me, "Are you getting enough sleep?" If the health care professionals could do a mini interview with pregnant women and determine what is going on with them in their lives, maybe they would get a sense of women who are at risk. They need to really know what is going on in women's lives. (#7, second interview).

On the other hand, Isla recalled her own experiences with her doctor whereby she told her doctor that she was tired and had no energy and she felt that her comments were minimized.

I would walked into the doctor's office and say, I'm tired and I have no energy. The doctor replied that I was a mother and I was supposed to be tired and have no energy. So I was put into that category. The doctor should have asked, "Do you think you are tired because you aren't getting enough sleep?" A very common symptom or prevalent sign it that you can't sleep. So, if they ask the question, "are you sleeping when you can?" It could be an interesting trigger (#8, second interview).

Currently, there are at two screening methods for postpartum depression that are available to practitioners; the Edinburgh Postpartum Depression Scale (Cox et al., 1987) and the newly developed Postpartum Depression Checklist (Beck, 1993). The Edinburgh Postnatal Depression Scale is actually a self-report questionnaire that mothers themselves complete. The Postpartum Depression Checklist is designed to be administered by a health professional, thereby engaging mothers in a dialogue (Beck, 1993, p. 308). It is widely acknowledged in the literature and in the results of this study that there is a poor detection rate for postpartum depression. These screening tools should be used by health
professionals during the first year postpartum to ensure that women experiencing
postpartum depression receive treatment.

Approaches to working with women who are experiencing postpartum depression
vary according to the current practice literature, with a wide range of opinions being
expressed in terms of how best to practice with this population. Medication, individual
psychotherapy, group psychotherapy and self-help groups are the most common
interventions. As evidenced in the results of this study, medication was recommended to
all of the women although some chose not to take the antidepressants, some of the women
were seeing a psychiatrist, all of the women had participated in self-help groups, and
some women were involved in a combination of treatment modalities. Again, I would
urge professionals to inform and educate women about the various options available to
them rather than assuming that the women are not capable of making an informed
decision. I am more specifically referring to the use of medication. In many cases,
medication may be an appropriate form of treatment that allows women to emerge from
the depths of despair and to attain a place of energy that allows them to seek support
groups or individual counselling. However, from the stories of these women, it was
evident that the practitioners assumed that medication was the best choice for the women.
At the same time, there were differing opinions with respect to the use of antidepressants
and the continuation of breastfeeding. Some women were told they had to stop
breastfeeding in order to take medication while others were informed that they could
breastfeed and take antidepressants. While I am aware of the fact that existing studies are
providing contradictory findings with respect to this issue, it is unfortunate that women
are receiving mixed messages. I would suggest that professionals tread carefully in this
regard and make every attempt to educate themselves about the current research and
provide women with an opportunity for discussion around this choice of treatment. Vicky
made the following statement about her own experience.
The physicians just wanted to give you antidepressants. I felt that they didn't trust me to make my own path or choices. That was discouraging (#6, second interview).

Women must be provided with clear and precise information with respect to the use of antidepressants and subsequently should be supported in whatever decision they choose. Women are often experiencing enough guilt and confusion with respect to the label of depression. Thus, it is essential that they be consulted, educated and supported with respect to the use of medication.

I feel that it is also worth mentioning that one of the women in the study who was hospitalized with her depression expressed her sentiments about her experience in the hospital. Kanelli wanted to transmit a message to the doctors with respect to co-hospitalization of mothers and babies.

I would like to tell doctors and professionals to try and do something in the system to hospitalize women with their babies when a person is sick. I don't know how hard it is to have a section in the hospital where they can look after these women. I just needed the security of having people around me (#3, second interview).

She felt that she should have been allowed to have her baby with her at the hospital. Again, the guilt and feelings of inadequacy women are already experiencing are only further reinforced when they are given the message that they are also incapable of looking after their child. This is an important issue that must be taken into consideration with respect to hospital policy development.

When women visit their doctors or when community health nurses visit new mothers, there needs to be more focus on the emotional health of women. New mothers are particularly dependent on advice from the medical establishment yet they can often be labelled as over-involved or dismissed with comments such, "oh, all new mothers experience that. It will pass." I believe that these statements made by the women in this study provide invaluable information for health care practitioners. These women have been through the devastating experience of postpartum depression. It only stands to reason that their insights can and should inform the practice of professionals.
The women in this study also provided some wonderful and reassuring messages for new mothers and for women who may be experiencing postpartum depression. The significance of these statements is that this information can be utilized not only by practitioners in their initial contacts with women but also in their ongoing work with the women whether it be as a doctor, health nurse, group facilitator, social worker or therapist in private practice.

As mentioned previously, many of the women in this study were depressed for an extended period of time before receiving help. Isla felt strongly that women should receive the following message if they think they are depressed and are ambivalent about seeking help.

If you think you are, then you are because a happy person doesn't think that way. All women that I have talked to have had some form of it, have had something to some degree. I've talked to women who have never received help. They suffered a long time (#8, second interview).

Isla further wanted women to know that if they are suffering from postpartum depression it is not their fault; we need to consider the structure of our society with respect to support for mothers.

It has a lot to do with society. It is not all hormonal. Society has changed. Your expectations of being a mom has changed. Your ability to network with your neighbours has changed. In the old days, maybe you didn't have extended family but you did have the extended neighbourhood. Before you started spiralling downward, family, neighbourhoods or the church used to be intervening at that point. It's different with our generation (#8, second interview).

Laura felt strongly that she wanted women to know about self-care and their rights to get their needs met and to ask for help.

Maybe women should have one of those self-care sheets. Have I eaten? All those things that we don't do when we are taking care of people. Did you go to the bathroom or are you holding it for three hours like we do when we are caring for others? I think it is important for new mothers (#7, p. 21).

Vicky felt that it was essential for women to chip away at the old guilt block.
Try not to beat yourself up that this is happening. Be really gentle to yourself. And you are not a bad person because this is happening. Make sure you take care of yourself because you have to take care of yourself before you can take care of your family (#6, second interview).

Many of the women expressed the need for women to seek help despite the fact that they may be feeling embarrassed or ashamed about their situation. The following quote by Amanda speaks to this issue.

It is important to find someone to talk to, a group or a friend. I know that some people have a hard time talking about it. Shame. It is nothing to be ashamed of. (#6, second interview).

Jennifer encouraged women to try looking at the bigger picture and putting a plan into place for themselves to deal with the feelings of despair and sadness.

I would want to reassure women ....the one thing would be that I would encourage them to write down and think about the big picture. What is this all about? And to have a hope manual. Should things become hopeless and for myself as I fear depression coming back, I would write in a book so that when I couldn't think and things seemed black, I could go back an read, "this will not last forever or whatever. Journal writing, I guess (#4, second interview).

Kanelli felt strongly that women need to be prepared for the worst and should be sure that they have lots of support in place prior to the birth of the baby.

And to the ladies, be ready. Maybe it won't happen but you need to be prepared. Like, practical help, getting help in place. Have a list of people that you can ask to help. You are expected to do it by yourself. You are expected to do it. People will say, "millions of other ladies have done it before you." So you are expected to cope. People need to listen to this. We talk about drugs and anorexia and this is something else we have to listen to (#3, second interview).

Laura shared the following thoughts with respect to her own situation.

And for someone who has postpartum depression, I want them to know and these were the two best pieces of advice I received, learn to accept it because you won't know why it happened and that everyone gets over postpartum depression and it won't last forever and there will be an end (#7, p.21).

Given that the women in this study strongly advise other women to talk about their experience, strategies for intervention by health practitioners would do well to use this
information as a starting point for their own practice. At the same time, some of the
women alluded to the fact that it was very difficult to talk about their feelings of despair
and distress because they were ashamed. This makes it even more essential that health
care professionals who have contact with women after childbirth be cognizant of the fact
that they should be encouraging women to speak about their experiences of motherhood
and begin normalizing and validating the realities of these women's lives.

As described, the findings of this study have important implications for informing
the practice of professionals and the implementation of policy and programs. Practitioners
need to begin questioning the prevalent assumptions in the literature not only about
postpartum depression but also with respect to the ideology of motherhood. Additionally,
it must be recognized that the information provided by the women in this study has
contextualized their experiences. Therefore, rather than simply categorizing women as
having "postpartum depression" and implementing a treatment plan, practitioners must
take their individual situations into consideration. In other words, in order to be effective,
interventions by professionals need to recognize and take account of mothers' own
explanations of their problem and their own ideas concerning what might constitute an
appropriate solution. This type of information can be used by practitioners to begin
assessing the adaptation of new mothers, to begin sensitizing themselves to the potential
warning signs as means by which to prevent the process of spiralling downwards and to
better understand the varying needs of women during the recovery process. Additionally,
incorporating standard practices into existing health care policy with respect to services
for new mothers and assessment, intervention, prevention and treatment for postpartum
depression is essential. Whatever action is taken in the future, it would appear that at
present, there is a considerable need for assistance that is not available and accessible.

**Implications for Further Research**

My research clearly indicates a strong relationship between the women's recovery
from postpartum depression and their involvement in the self-help support groups offered
through the Pacific Post Partum Support Society. The value of allowing women to talk about their feelings in a supportive, non-judgmental and safe environment seems to be effective in reducing levels of depression amongst women. I believe that further qualitative research in this area would be useful as it could provide insight about the specific aspects of the group that were central to the recovery process. Additionally, the results of such research would provide credible data that could enhance the ongoing and future funding of this necessary and valuable means of treatment.

Another area for further research would be a more in-depth qualitative study that explores the differences between women who have experienced postpartum depression and those who have not with respect to the issues associated with the adjustment to motherhood. Specifically, it would be interesting to determine why some women move beyond the realm of typical postpartum adjustment and spiral downwards while others do not. Although I was able to draw some conclusions from this study with respect to lack of support and issues of loss, the study as conducted only opens the door to such issues and cannot be considered conclusive in all aspects of the adjustment to motherhood. Furthermore, the study as presented does go a long ways to depicting specific issues and circumstances associated with depression after childbirth; however, the questions remains as whether the issues presented constitute necessary predisposing factors or simply coincidental occurrences. Studies conducted in the future could bring together data such as that presented in this study and data developed from similar studies of new mothers not experiencing depression after childbirth.

Qualitative research that seeks to explore the knowledge, beliefs and attitudes of health care professionals with respect to postpartum depression could be conducted. It is evident from my study that, in general, attitudes of health care professionals ranged from cynicism and minimizing to full knowledgeable support. This range of perspectives on behalf of health care professionals introduces a significant potential barrier to new mothers experiencing depression after childbirth. In addition, similar barriers could be presented to
women for whom the process of seeking help is occurring prior to experiencing postpartum depression. A qualitative study in this area could provide answers to such questions as: what are the opinions of health care practitioners with respect to their knowledge about emotional reactions affecting mothers?; do they feel they have sufficient knowledge about postpartum depression?; and what are the routine practices of health care practitioners with new mothers?

**Limitations**

This study, although providing an opportunity for further directions, must be examined in the proper perspective. Any study must involve choices by the researcher. Those choices can be discussed and rationalized to attempt to justify particular decisions and directions. These very situations, although related in their entirety, can still limit the scope of the study. I believe that it is important to recognize the limitations of my own study; however, I am confident that the limitations to be discussed do not impede the findings of this project.

One very important limitation to this study is not related to methodology per se, but is related solely to my practical lack of first-hand experience with depression after childbirth. It is difficult to try and visualize the depths to which some of these women descended. They told me, I listened and I incorporated their stories into the project. Although I was able to empathize with their stories of despair and triumph, I could not understand completely without having had a similar experience.

Likewise, while the issue of reflexivity or the acknowledgment of researcher bias can be considered a strength in the research process, it can also be recognized as a limitation of the study. My own strong beliefs with respect to the oppressive state of motherhood and the unnecessary medicalization of postpartum depression certainly had an influence on the study as a whole. While I made every attempt to hear the women's perspectives about their experiences, there were certain areas of the research process that may have been influenced by me.
In contrast to the personal views discussed above, there are practical issues related to the design of the research that can also be considered to be limitations. I realize that by obtaining my sample from a particular agency that provides a specific type of support for women experiencing postpartum depression could be considered a limitation. In other words, a more diverse sample that included women who did not utilize the services of this agency may have provided increased insight and depth of understanding. Additionally, it would have been preferable to have women from varying race, class, and culture; however, the Pacific Post Partum Support Society has had very few participants from other cultures. Thus, I was limited in terms of the diversity of my sample.

In summary, I believe that the findings of this study supported, enhanced and challenged the existing state of literature with respect to women's emotional health during motherhood. Additionally, the knowledge incurred from the stories of these women provide tremendous opportunity for informing professional practice, implementing policy and programs and conducting further research initiatives with respect to the phenomenon of postpartum depression. Finally, I feel that it is essential for me to recognize the limitations inherent in this study. By openly discussing these limiting factors, the results of this study are brought into proper perspective. In turn, acknowledgment of these limitations can provide insight and information for further research studies in the area of depression after childbirth.
Conclusion

The blending of the words of the women in this study has created a picture of a devastating time in their lives; a picture of the pain, the darkness and the despair that surrounded their worlds during their experiences with depression after childbirth. Their words, however, also spoke of the creation of hope and the long, exhausting pilgrimage towards the light at the end of the tunnel. The journey was an arduous one on a road that was constantly changing directions and presenting obstacles. The women went through an incredible ordeal and they survived. They spoke of the ambivalent feelings often associated with motherhood, the contradictions, and the confusion. That is to say, while motherhood can be very fulfilling, there is a lack of acknowledgment of the emotional and physical stress associated with mothering in our society. Our society creates an environment which makes mothering an almost impossible task. In fact, don't these women's stories indicate that women have every right to be depressed with their life as mothers in this society?

Depression after childbirth is a real and debilitating condition for some women and their families. It can have long-term effects on the woman's relationship with her child and her partner. While motherhood can be one of the most fulfilling experiences of a lifetime, it can also be a time of unfulfilled expectations and personal loss. The overwhelming transition to motherhood is intensely stressful and is accompanied by physical exhaustion, isolation, changes in significant relationships, the burden of child-rearing and housework and so forth. Disillusionment and unhappiness are often inevitable. Unfortunately, this unhappiness is often trivialized or ignored and women are left to deal with the despair on their own. Many of them suffer in silence for fear of disapproval and rejection. Don't the stories of these women clearly indicate that there are many people who remain uneducated and uninformed about women who are experiencing depression after childbirth?
The present literature on postpartum depression is still dominated by a medical model that sees "something wrong with women" when in fact, depression after childbirth can be viewed as a natural response to the socially constructed image of "the perfect mother". In addition, postpartum depression is a women's health issue yet there are very few qualitative studies and feminist research that reflect women's voices. Quantitative methods have sought to identify causes and predictors of depression after childbirth and I seriously challenge the ability of this objective measure to reflect the true experience of women. In actual fact, the use of quantitative measures to seek a single truth or reality negates the diversity of women's experiences. The very nature of human experience requires the acceptance of diversity. To simply attribute women's distress to psychological or physical malfunctioning frees this society from looking at the social causes of unhappiness. In other words, is the woman supposed to change but nothing around her needs to change?

These quantitative measures have not helped us to identify causes and predictors of postpartum depression. The existing literature presents contradictory findings. Likewise, the lack of research that looks at women's experience of depression after childbirth from their perspective means that the interventions that do exist are based upon our assumptions of what women want and need. The women in this study provided some very definite ideas about what they felt they needed during this difficult time in their lives. Does it not make sense to listen to their voices with respect to the recovery process?

There is a gap in the existing body of research and I feel that conducting feminist research using qualitative methodology will validate women's accounts of their experience with depression after childbirth by allowing language which, in turn, can create new knowledge. This knowledge and new perspective can be utilized by social workers in the many settings where they provide services to women and their families. Feminist research can offer a much-needed alternative for improving not only our understanding of women's mental health needs and the services required but can also assist women to recognize the
source of the nature and causes of their oppression as imbedded in the existing ideology of motherhood.

I am in no way negating the pleasures and fulfillment that also accompanies motherhood, but unless women begin to receive the necessary support and recognition for this difficult life transition, emotional reactions after childbirth shall continue to be highly prevalent in this society. Women must be freed from the myths of motherhood and freed from the roles that are prescribed and dictated by society. At the same time, the spectrum of emotional reactions encountered by new mothers as they leap into unexplored territory must be recognized, valued and supported. I believe that we have unrealistic expectations of women, in general, and mothers in particular and the combination of these expectations can place any woman at risk for depression after childbirth. Before anyone can possibly survive the expectations developed and articulated before the birth and during the early days of motherhood, motherhood itself must be re-examined openly and honestly such that the ideology of motherhood can be reconstructed and then utilized by society to form more realistic expectations with respect to the role of mothering. The fact remains, however, that postpartum depression is affecting many women in our society. Also, the reality is that women are clearly experiencing strong emotional reactions to the transition to motherhood, yet their cries for help continue to be unrecognized. The women in this study have shared their most intimate feelings, thoughts and memories about their experience with depression after childbirth. To honour, validate and support their stories, it is essential that their words be accepted as a valuable and necessary contribution to the existing body of knowledge about depression after childbirth.
REFERENCES


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Appendix G

Interview Guide

1) Please tell me anything you would like about your experience after the birth of your child/ren?

2) Can you tell me what you called this experience and why you called it what you did?

3) What do you feel may have contributed this experience?

4) What helped you get through this experience?

5) i) Could you tell me about what you thought motherhood would be like?  
   ii) Is your experience of motherhood different than you thought it would be?

6) What would you want to tell women who might be experiencing emotional reactions after childbirth?

7) What would you want health care professionals that work with new mothers to know?

8) What would you want family members or friends to know?

9) Is there anything else about your experience that you wish you would have asked about but have not?
Appendix H
Women's Experiences With Depression After Childbirth: A Retrospective Model

WHY DID THIS HAPPEN?

Vulnerability
- previous depression
- life changes
- problematic relationships
- ambivalence about pregnancy

Incongruity Between Expectations and Reality
- birth experience
- self as mother
- life with baby
- support from family and friends

WHY DID THIS HAPPEN?

Incongruity Between Expectations and Reality
- physical changes
- relationship with partner
- support from family and friends

Shattered Dreams
- changing relationship with partner
- disillusionment with motherhood
- who am I?

Losing Control
- what is happening to me?
- isolating self
- falling off the edge

GETTING TO THE OTHER SIDE

Spiralling Downward
- adjusting expectations
- meeting needs

Rebuilding of Self
- recognizing and meeting needs
- coming to terms

Creating of Hope
- feeling better
- I'm not alone

Surrendering
- help seeking
- dealing with the label
- medication struggle

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Appendix I

Summary of Implications for Practice

1. Parenting groups for expectant parents and new parents are one avenue in which to begin deconstructing the myths of motherhood while also serving to educate couples about depression after childbirth.

2. Maternal depression continues to go undetected and untreated in our society. Health care practitioners must become more educated about postpartum depression. Screening tools have been developed that can assist professionals in assessing for risk and detection of postpartum depression.

3. At the same time, health care professionals must question the prevalent assumptions in the literature about the diagnosis and treatment of postpartum depression.

4. A holistic approach to treatment is essential. Rather than simply categorizing women as having "postpartum depression" and implementing a treatment plan, practitioners must recognize and take into account the mothers' own explanations of their problem and their own ideas concerning what might constitute an appropriate solution.

5. The findings of this study will contribute knowledge to the clinical practice of social workers, therapists and counsellors who are working with women seeking professional help to deal with their postpartum depression.

6. Due to the implementation of early discharge programs in the hospitals, comprehensive community services must be established to assist new mothers and their families with the transition to parenthood and reduce the risk of postpartum depression. Interorganizational collaboration is a means by which different groups of health care professionals can work together to produce socially beneficial programs for new mothers while reducing duplication of effort, service and financial resources.

7. At a societal or more ideological level, we must begin normalizing emotional reactions to motherhood. The ambivalent feelings that many women have towards motherhood must be acknowledged. We must begin dispelling the myths of motherhood so that women are not feeling that the strong emotional reactions they may be experiencing are a sign of individual inadequacy.