WOMEN'S EXPERIENCES OF SEEKING AND RECEIVING HELP
FOR POSTPARTUM DEPRESSION

by

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Abstract

Postpartum depression (PPD) is a serious health issue that affects 13% of women worldwide and has serious consequences for women and their families. Despite regular contact with healthcare services in the postpartum period, PPD remains largely unrecognized by women themselves, and undetected and untreated by healthcare providers. This study comprises the qualitative component of a collaborative four-part research project that explored the phenomenon of PPD. Grounded theory, a method aimed at generating a substantive theory about social phenomenon, was used to guide the research process. Thirty women who identified themselves as having experienced PPD participated in one of six focus group discussions conducted in the Fraser Valley Health Region of British Columbia. Constant comparative analysis of the qualitative data revealed a complex and evolving process of help seeking for PPD consisting of three phases. Women’s choices of when to seek help, whom to seek help from, and what kind of help to seek differed among phases. The first phase, waiting to be rescued, was described by the women as falling apart, trying to survive, having nowhere to turn, and reaching the end of the line. Reaching the end of the line was a significant turning point in the help seeking process. The second phase, giving in and opening up, was characterized as putting self at risk, knocking on doors, trying out options, being influenced by beliefs about help seeking, and feeling better. Feeling better was experienced as an uneasy peace in which women continued to feel vulnerable to relapse. The third phase, tuning-in to self, was identified as looking back, moving forward, and finally a new sense of self, forever changed but ultimately wiser and stronger. Breaking the silence emerged as the core category in this substantive theory that describes women’s difficult journey from silence to voice. The theory generated from this study increases knowledge about this important and difficult human experience and guides nurses in the assessment, planning, implementation, and evaluation of nursing care for women who experience PPD.
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Dedication

This thesis is dedicated with love and admiration to my big sister Judy.

Judy,

I am forever grateful for your love and kindness,

for it has sheltered and protected me since childhood.

Forever sisters — forever friends!
CHAPTER ONE: INTRODUCTION

Depression ranks as one of the most debilitating and painful of human experiences (Munoz, Ying, Perez-Stable, & Miranda, 1993). Depression following childbirth, commonly known as postpartum depression (PPD), affects approximately 13% of women worldwide (O'Hara & Swain, 1996) and has been shown to have serious consequences on the health and well being of mothers, on family functioning, and on child development (Ballard & Davies, 1996; Beck, 1998, 1999; Fowles, 1998; Lovejoy, Graczyk, O'Hare, & Newman, 2000; Murray & Cooper, 1996; Murray, Hipwell, Hooper, Stein, & Cooper, 1996; Sharp et al., 1995). Although Canadian national statistics are unknown, two small studies in Montreal found PPD rates to range between 12%-16% (Bernazzani, Scucier, David, & Borgeat, 1997; Da Costa, Larouche, Dritsa, & Brender, 2000). The exact extent of this problem in British Columbia (BC) is unknown.

PPD occurs within an intricate social context that includes a unique dyadic relationship between mother and baby (Wood, Thomas, Droppleman, & Meighan, 1999). Researchers have hypothesized that a mother's depressive symptoms may influence her interpersonal functioning and parenting abilities leading to impaired child development. PPD has been linked directly, and indirectly, to negative maternal-infant interactions (Beck, 1995a; Lovejoy et al., 2000), negative maternal perceptions of infant behaviour (Beck, 1996a; Whiffen, 1990), cognitive and emotional developmental delay in children (Murray et al., 1996; Sharp et al., 1995), behavioural and social problems in children (Beck, 1999; Murray & Cooper, 1996), child neglect and abuse (Buist, 1998), and subsequent episodes of maternal depression with the birth of other children, or outside the perinatal period altogether (Beck, 1998a). Although the experience of parenting a child in the midst of a depressive episode has not been well described in the literature, recent qualitative research is beginning to expand our knowledge of this phenomenon. For instance, in a
qualitative study that explored the meaning of postpartum depressed mothers’ interactions with their infants, women described being overwhelmed by childcare responsibilities, experiencing guilt, thinking irrationally, experiencing feelings of loss and anger when interacting with their children, and acting like robots while they provided childcare (Beck, 1996b).

Despite regular contact with healthcare services in the postpartum period, PPD remains largely unrecognized by women themselves, and undetected and untreated by healthcare providers (Whitton & Appleby, 1996). Many women do not even recognize that there is something wrong, believing their symptoms to be a normal response to the childbirth experience and the new demands of parenting (McIntosh, 1992; Whitton & Appleby). For those women who do recognize the seriousness of their symptoms, the social stigma of mental illness and the perception that others are unable to provide appropriate care prevents many women from seeking help (McIntosh). In addition, many healthcare providers lack adequate knowledge and skills to recognize symptoms of depression and very few use a validated screening tool to identify women at risk (Hearn et al., 1998). Women who do seek help often complain that healthcare providers tend to minimize their symptoms or try to convince them that what they are experiencing is normal (Beck, 1993b).

In general, treatments for PPD have been derived from predominantly biomedical and psychological models. Although the most effective treatment, or combination of treatments, is not clear, traditional interventions have tended to be one-dimensional in nature, using either pharmacological or cognitive-behavioural/counselling approaches. In more recent years, psychosocial approaches that take into consideration the importance of social support as a significant predictor of depression have been developed (Brugha et al., 1998).

Public Health Nursing Services for Postpartum Women and Infants in BC

Community followup of postpartum mothers and infants is an important component of
public health nursing services in BC and the public health nurse (PHN) is often the most likely health professional to identify a new mother’s symptoms of depression and to provide her with her greatest source of support (Handford, 1985). Women recognized to be suffering from depressive symptoms are routinely provided with one-to-one nursing care, referred to family physicians for medical assessment, or encouraged to contact other community agencies for support. Postpartum care provided by PHNs includes an assessment of maternal mood. Although a tool specifically designed to assess for PPD has not been part of standard practice, the provincial government has recognized the serious impact of PPD on child development and family functioning. In the early 1980’s the BC Provincial Ministry of Health adopted a Nursing Priority Screening Tool in which PHNs use a multifactorial risk assessment to identify infants at risk for developmental delays, failure to thrive, neglect and abuse, or physical or emotional problems secondary to other handicaps (Parkyn, 1985). The Parkyn tool identifies PPD as a significant risk factor for such problems.

Unfortunately, two recent program changes in BC aimed at improving maternal and infant health services, have negatively affected the ability of PHNs to detect women with PPD. Firstly, the transfer of prenatal education to the private sector has resulted in a significant reduction in PHN contact with women during pregnancy, a critical time for detection, and perhaps even prevention of PPD. Secondly, the shift of postpartum care from hospital to community has placed increased demands on PHN services for women in the very early postpartum period. In many regions of the province this change in PHN practice has resulted in the reduction, or even elimination, of traditional PHN prevention visits to women at four to eight weeks postpartum, a time when depression is most likely to occur and be recognized.

To compensate for these program changes PHNs have initiated mother-baby support groups and drop-in clinics aimed at increasing access to health unit services for new mothers and
infants during the critical first year of a child’s life. These services have been well received by clients who attend, however, they do not attract large numbers of women, particularly those with transportation or financial difficulties. In addition, the tendency of women suffering from depression to withdraw from social contacts may make it particularly difficult for these women to attend group sessions (Mauthner, 1995).

Fraser Valley Health Region (FVHR) Program Planning for Women with PPD

Every year approximately 3,000 mothers give birth in the FVHR (Fraser Valley Health Region, 2000). If the worldwide PPD prevalence rates of 13 per 100 women apply, it follows that 390 women in the FVHR each year, may experience significant symptoms of depression after the birth of their babies. Although accurate data on the numbers of new mothers identified at risk for depression within the FVHR are not available, many PHNs have expressed concern that very few women who experience PPD are detected, provided with public health nursing care, or referred to other services. To date, no consistent, co-ordinated mechanism exists within the region to detect new mothers suffering from depression or to document the incidence and prevalence of the condition.

For women who have been identified with PPD, medical, nursing, and counselling interventions within the FVHR tend to be scarce, fragmented, and inconsistent. Currently there is only one support group in the region and access to the Pacific Post Partum Support Society, a not-for-profit society that provides support to women and families experiencing depression related to the birth or adoption of a baby is limited due to significant travel distances and the cost of travel and telephone charges. Although lack of social support has been shown to be a strong predictor of PPD (O’Hara & Swain, 1996), psychosocial approaches such as mother-to-mother telephone support have not been initiated within the region. In addition, no community needs assessment has been undertaken to determine women’s experiences of PPD and their preferences
for care.

The Fraser Valley Regional Health Board (FVRHB) has identified the prevention and treatment of PPD as a priority for healthcare planning. Lack of knowledge about the nature and extent of the problem, lack of tested intervention alternatives, and perhaps most importantly, lack of understanding about women's experiences of care hinders program planning. The managers of the FVHR are committed to helping new mothers who experience depression and believe that program planning and policy development that will address women's unique health needs must be based on sound evidence, including an understanding of women's experiences as related by women themselves. Existing theories do not adequately explain the phenomenon of PPD and therefore a return to women's own descriptions of their experiences and feelings becomes critically important as a means to gaining new insights (Jack, 1991).

To enhance public health nursing services the FVHR has undertaken a unique research project consisting of four interrelated studies. The primary goal of this project is to conduct research that will provide the FVHR with valid, women-centred, empirical findings that will direct the development of appropriate, effective, and efficient healthcare services for women who experience PPD. A secondary goal is to develop collaborative practice-research links through an innovative partnership between researchers from University of British Columbia (UBC) Faculty of Medicine, UBC School of Nursing, and Public Health Nursing Services of the FVHR. A concise overview of this research project is provided in Appendix A. This work presents the findings of Study One.

Statement of the Problem

Although much research has been conducted into the nature, prevalence, aetiology, and outcomes of PPD, very little is known about women's experiences of seeking and receiving help for PPD. To gain a deeper understanding about this serious health issue it is critically important
that healthcare providers listen to the voices of women. This study explored the following research question: What are women’s experiences of seeking and receiving help for PPD?

Purpose

The purpose of this qualitative study was to explore women’s experiences of seeking and receiving help from family, friends, and healthcare providers for PPD and to identify and describe their process of help seeking. The new knowledge, understanding, and insights gained from this inquiry are essential to informing clinical nursing practice and providing a relevant approach that is mother and family-centred.

Assumptions

This study was founded on the following assumptions:

1. The women in the study were knowledgeable about the phenomenon of PPD and were able to communicate their experiences to others.
2. The researcher was able to understand behaviour from another person’s point of view.
3. Group interactions in focus groups enhance the depth of a conversation because of the stimulation provided by group members and produce data and insights that would be less accessible without such interactions (Cote-Arsenault & Morrison-Beedy, 1999; Debus, 1993)

Significance of the Study

PHNs play a major role in the delivery of healthcare to new mothers and infants and recognize the unique health needs of women who experience PPD. Unfortunately without a more in depth understanding of the experience of PPD from women’s perspectives PHNs lack the insight needed to plan and design appropriate programs or prevention interventions. Therefore, this study was deemed to be important because the theory generated was expected to increase knowledge and understanding about this important and difficult human experience and to provide a focus for assessment, planning, and implementation of appropriate and effective
nursing care for women who experience PPD.
CHAPTER TWO: REVIEW OF THE LITERATURE

Overview

In this chapter the literature relevant to the phenomenon of PPD is presented followed by a discussion of general research focused on the definition of PPD within the spectrum of mood disorders occurring in the postpartum period, the prevalence, aetiology, and nature of PPD, and common assumptions made within the current research literature. Finally, information related to the impact of PPD, common intervention approaches, factors influencing the recognition and detection of this condition, and women’s help-seeking behaviour is presented.

Sources of Literature

The databases of CINAHL, Medline, and PsychINFO were searched from the years 1980 to 2000 using the keywords of postpartum depression, postnatal depression, help seeking behaviour, and barriers to health. As the data analysis proceeded, new themes emerged and additional research studies related to the concepts of recovery, relapse, panic disorder, loss of self, and the experience of depression for other populations, were located. Reference lists from selected articles were reviewed and historical records maintained by the public health unit were obtained.

The majority of the existing research literature on PPD focuses on its nature, prevalence, and aetiology, the development of screening tools, and the impact of maternal depression on child development and family functioning. Most of the research studies are quantitative in design and conducted by physicians, psychiatrists, nurses, and psychologists. Although research has been conducted in several countries, the vast majority of the research work has taken place in Great Britain, the United States, Canada, and Australia. Nurse researchers have played a vital role in the development of new knowledge about PPD through the conduct of quantitative studies using secondary analysis (Hall, Kotch, Browne, & Rayens, 1996), meta-analyses (Beck, 1995a,
1996a, 1998, 1999), and longitudinal descriptive designs (Affonso, Lovett, Paul, & Sheptak, 1990; Fowles, 1998). In addition, nurses are leading the way in the conduct of qualitative studies that explore the experiences of PPD from women’s perspectives (Beck, 1992, 1993b; Nicolson, 1990, 1999; Wood et al., 1999) and the experience of recovery from depression for women at other times in their lives (Chernomas, 1997; Peden, 1993; Schreiber, 1996; Steen, 1996; Unsworth, 1999). Findings from these studies have provided a greater understanding about the lived experiences of women with depression, their social relationships, and their perceptions of motherhood.

General Research Issues

The Spectrum of Postpartum Mood Disorders

Currently, PPD is seen to be a distinct entity that lies along a spectrum of postnatal mood disorders and is defined in terms of symptom severity, onset, duration, prevalence, and aetiology. The common understanding from current empirical research is that affective disorders following childbirth range in severity and duration from the nearly ubiquitous, mild, and transient “maternity blues” experienced by 50-80% of women (Pariser, Nasrallah, & Gardner, 1997) to postpartum psychosis, a severe form of psychiatric illness affecting less than 0.1% of mothers (Llewellyn, Stowe, & Nemeroff, 1997; Nonacs & Cohen, 2000). Maternity blues are characterized by symptoms of tearfulness, anxiety, insomnia, irritability, and lability of mood beginning a few days after delivery and lasting from 1 to 10 days (Beck, 1991; Llewellyn et al.; Nonacs & Cohen). In contrast, postpartum psychosis presents with hallucinations, delusions, depersonalization, psychomotor disturbances, and disorganized behaviour that most often occurs within 2 to 4 weeks of childbirth (Klompenhouwer et al., 1995; Nonacs & Cohen). Women who experience postpartum psychosis frequently require hospitalization (Epperson, 1999). Although postpartum psychosis was familiar to most physicians by the late nineteenth century, the notion
of an "atypical" depression (later called maternity blues) was not described until the 1960's. The concept of PPD, a more severe non-psychotic depressive episode first emerged in the scientific literature in the 1970's (Nonacs & Cohen).

Definitions of PPD

The research literature reveals a wide variation of definitions for PPD ranging from standardized diagnostic criteria to "the presence of depressed mood for 2 weeks at any stage in the first postpartum year" (McIntosh, 1992). Interestingly, standardized diagnostic criteria for depression in the postpartum period are the same as for non-psychotic major depression that occurs at other times in women's lives (Nonacs & Cohen, 2000; Pariser et al., 1997). The Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV) identifies nine symptoms of depression that are divided into two subgroups (American Psychiatric Association, 1994). Psychological symptoms include: depressed mood or reduction of interest and/or pleasure in activities including sex; feelings of guilt, hopelessness and worthlessness; and suicidal thoughts. Physical symptoms are: sleep disturbance, appetite/weight changes, attention/concentration difficulties, decreased energy or unexplained fatigue, and psychomotor disturbances. Diagnostic criteria that are outlined in the DSM-IV indicate that a diagnosis of major depression requires the presence of depressed mood or the inability to experience pleasure, plus four other symptoms for a period of at least 2 weeks. If depression begins within 4 weeks of delivery the modifier of 'postpartum onset' is often applied.

Prevalence

Studies of the prevalence of PPD have yielded widely varying estimates, ranging from 3% to more than 25% (Llewellyn et al., 1997; O'Hara & Swain, 1996), however, a meta-analysis of 59 studies estimated the prevalence of PPD to be 13% (O'Hara & Swain). While national statistics are unknown, two small studies in Montreal found PPD prevalence rates to range
between 12%-16% (Bernazzani et al., 1997; Da Costa et al., 2000). These rates are the same as the rates of depression experienced by women during pregnancy, as well as by women outside of the perinatal period (Cox, Murray, & Chapman, 1993; Green, 1998). Questions still remain as to whether PPD represents a continuation of prenatal depression or a pre-existing vulnerability to depression in general.

**Incidence, Onset, and Duration**

Generally, symptom onset occurs early in the postpartum period (Small, Brown, & Lumley, 1994), however, Beck (1996b) contends that symptoms may not occur until 12 months after delivery. Duration rates for PPD have been reported to range from 36 weeks (Cox et al., 1993) to 2 years or longer (Beck, 1996b) and recurrence rates for women who have had one episode of PPD are said to be as high as 50% (Nonacs & Cohen, 2000). Although the true incidence, onset, duration, and recurrence of PPD are difficult to ascertain because few studies have been longitudinal in design, there is widespread agreement among experts that women are at increased risk for depression in the prenatal and postpartum period (Romito, 1990).

**Aetiology**

Despite increasing emphasis placed by researchers and abundant sources of new data, the aetiology of PPD remains unclear (Horowitz, Damato, Solon, Von Metzsch, & Gill, 1995). A number of possible causes have been postulated, such as maternal biological and psychological factors, relationship factors, and life stressors. While no causal relationship has been established between a specific biochemical state of the brain or genetic factors (Bedi, 1999; Hendrick, Altshuler, & Suri, 1998; Treloar, Martin, Bucholz, Madden, & Heath, 1999), research findings suggest that PPD may be associated with marital difficulties, previous psychiatric history (including antenatal depression), lack of social support, and the occurrence of stressful life events (Lane et al., 1997; Mauthner, 1999; O'Hara & Swain, 1996). Unfortunately, the relative
importance of these factors is difficult to determine since few studies have attempted to integrate these risk factors into a specific multifactorial model of PPD.

The Nature of PPD

The nature of depression experienced by women in the postpartum period is more than just a set of symptoms that can be easily labelled and defined. Qualitative investigations are broadening our understanding of this complex phenomenon by exploring the subjective experiences of mothers. For instance, in a phenomenological study of seven mothers who had experienced PPD, Beck (1992) identified 11 themes that described the essence of the experience. These themes included unbearable loneliness, obsessive thoughts, loss of self, suffocating guilt, cognitive impairment, loss of previous interests and goals, uncontrollable anxiety, insecurity, loss of control of emotions, loss of all positive emotions, and contemplation of death. The experience of loss is a consistent theme throughout the research. Findings that have described the meaning and context of PPD have conceptualized loss as: loss of time and autonomy, loss of appearance, loss of femininity and sexuality, and loss of occupational identity (Beck, 1993b; Lewis & Nicolson, 1997, Nicolson 1999).

Assumptions About PPD and Non-Postpartum Depression

Assumptions about the nature of PPD have significant implications for research and practice. Although a substantial body of knowledge exists about depression occurring in the postpartum period, there is still considerable debate about the construct, PPD (Whiffen, 1992). Most of the research in this area has occurred within a medical, psychiatric, and experimental psychological framework that views PPD as an objective phenomenon, distinct from the depression experienced by women at other times in their lives (Mauthner, 1999). Research findings based on this medical model suggest that factors differentiating PPD from non-postpartum depression (non-PPD) include: symptom onset occurs within 4 weeks of delivery.
increased frequency of disturbing, aggressive, obsessional thoughts (Wisner, Peindl, Gigiotti, & Hanusa, 1999), less severity of symptoms (Whiffen), and increased feelings of guilt and inadequacy related to being an incompetent and inadequate mother (Fowles, 1998).

In recent years research from social scientist and feminist perspectives has challenged the assumption that PPD is a distinct entity. Some feminist researchers had critiqued the medical model for regarding PPD as a pathological condition rooted in deficiencies of the individual mother (Mauthner, 1999) and argue that PPD may actually be a normal grief reaction to the experience of loss and change experienced during the transition to motherhood (Nicolson, 1990; Romito, 1990; Whiffen, 1992). Other feminist researchers have viewed PPD from a relational framework that views human beings as embedded within complex social interactions. Findings from Mauthner’s study suggest that PPD occurs “when women are unable to experience, express, and validate their feelings within supportive, accepting, and non-judgmental interpersonal relationships and cultural contexts” (p. 143). The construct of PPD remains to be clarified, however, it is important to recognize that assumptions about the nature of PPD have significant implications for research and practice. Objective knowledge about PPD will be incomplete without a better understanding of the subjective experiences of women within the context of their lives as wives and mothers.

**Recognition of PPD**

PPD represents a largely unrecognized and under-reported area of maternal morbidity (Hearn et al., 1998; McIntosh, 1992). The literature suggests that there are two significant barriers to the recognition and detection of PPD. Firstly, although many women recognize that something is wrong they do not attribute their unhappiness to depression, believing that it is normal to feel miserable after childbirth (Dew, Dunn, Bromet, & Schulberg, 1988). This belief is
supported in findings from an Australian study that showed that 18 of 45 women who perceived themselves to be depressed did not want to label it as postnatal depression but rather attributed their unhappiness to lack of support, isolation, fatigue, and poor physical health (Small et al., 1994). Secondly, many healthcare providers lack the knowledge and skills to identify depressive symptoms in new mothers. For example, in a study of 176 postpartum women, healthcare providers identified only 13 out of 30 women who had significant symptoms of depression according to the Edinburgh Postpartum Depression Scale (EPDS), an internationally recognized PPD screening tool (Bergant, Heim, Ulmer, & Illmensee, 1998; Cox et al., 1993). Similar results were found in a study that examined the ability of health visitors to identify depression in new mothers (Sheppard, 1996). In this study of 108 postpartum women health visitors detected only 3 of 9 women who were identified as being at risk for PPD using a validated PPD scale. These same health visitors mistakenly identified seven women as depressed who were not depressed according to the screening tool. These findings are confirmed in a study conducted in Great Britain that examined whether use of the EPDS at postnatal examinations would detect women not recognized as depressed by members of the healthcare team (Hearn et al.). The researchers found that despite an average of 14 contacts in the postnatal period, nearly one half the women likely to be depressed were not identified as such by any member of the healthcare team. In fact these researchers concluded that there was no correlation between mothers’ frequency of contact with healthcare providers and their mental health. These findings are particularly troublesome considering the fact that during the early weeks postpartum women engage in frequent contacts with healthcare providers.

Current Intervention Approaches

In general, treatments for PPD have been based on physiological/biochemical, psychological, psychosocial, and stress models of causation. The last 5 to 10 years have seen an
increase in research examining the effect of pharmacological, psychological, and psychosocial interventions on maternal mood and child health (Appleby, Warner, Whitton, & Faragher, 1997; Armstrong, Fraser, Dadda, & Morris, 1999; Fleming, Klein, & Carter, 1992; Lavender & Walkinshaw, 1998; Scott, Klaus, & Klaus, 1999; Shields & Reid, 1997; Steinberg & Bellavance, 1999). The following discussion focuses on the use of pharmacological, cognitive-behavioural, and psychosocial approaches to the treatment of PPD.

**Pharmacological Treatments**

Although a physiological/biochemical cause of PPD has not been supported in the literature, antidepressants, which function to increase the amount and efficiency of neurotransmitters, are often used successfully to treat PPD (Appleby et al., 1997). The efficacy of pharmacological treatments may be partially explained by the fact that antidepressants help to alleviate sleep and appetite disturbances, difficulties in concentration and thinking, and fatigue, thereby affording the individual more biological coping resources (Bedi, 1999). The lack of scientific evidence about foetal effects, however, has made it difficult for medical practitioners to reassure women as to the safety of antidepressant use during pregnancy (Bhatia & Bhatia, 1999; Pastuszak et al., 1993). Even though new studies are demonstrating that prenatal use of fluoxetine, a drug that inhibits the re-uptake of serotonin, is not associated with adverse effects on IQ, language development, or behavioural development in preschool children (Nulman et al., 1997), or malformations (Pastuszak et al.), pregnant women exposed to fluoxetine and tricyclic antidepressants have reported higher rates of miscarriage (Pastuszak et al.). In addition, the use of psychotropic medications during lactation has not been systematically investigated and the authors of two extensive literature reviews suggest that the prescription of antidepressants for breastfeeding women must be based on a risk-benefit basis (Llewellyn, Stowe, & Neveroff, 1998; Misri, Sinclair, & Kuan, 1997; Wisner, Perel, & Findling, 1996). Until further research is
conducted into the safety of antidepressant use during pregnancy and lactation, medical practitioners may remain reluctant to prescribe these medications. In addition, women may refuse to use antidepressants because of concerns about the safety of their developing foetus, fear of addiction, and belief that the depression will resolve on its own (Whitton & Appleby, 1996).

**Cognitive-Behavioural Therapies**

The assumption that PPD has a psychological origin has resulted in the development of cognitive-behavioural interventions aimed at alleviating psychological distress by correcting faulty beliefs (Whitton & Appleby, 1996). Strategies that provide counselling and cognitive-behavioural therapy have had some success. For instance, a program that improved the ability of health visitors to screen for PPD and to provide weekly non-directive counselling visits for women with PPD positively influenced the emotional well being of women (Gerrard et al., 1993). Non-directive counselling is a relationship-based approach, sometimes known as person-centred therapy, in which power is located in the client rather than the counsellor. The major assumption of this form of counselling is that individuals get to know themselves better and find solutions to their own problems if they are able to talk through their feelings with a warm, interested, and non-judgemental person (Holden, 1987). These counselling strategies may prove to be more successful when used in combination with medications and/or couple therapy (Appleby et al., 1997; Steinberg & Bellavance, 1999).

**Psychosocial Approaches**

In recent years, psychosocial interventions, such as professional or lay/peer support, including the use of self-help groups, have been offered as alternative or complementary approaches (Ray & Hodnett, 2000). Psychosocial interventions are based on the general association between social support and depression, as well as specific research that consistently reports social support to be a significant predictor of PPD (Brugha et al., 1998; O'Hara & Swain,
Findings from a Cochrane meta-analysis indicated that psychosocial interventions were associated with a reduction in depression at 6 months postpartum (Ray & Hodnett). In Canada, there are several self-help groups that offer support to over 60,000 women and their families each year (Partridge, 1996, September). Unfortunately, the efficacy of these support groups has not been studied and additional research is needed to explore the effect of peer support on PPD symptomatology.

Some interventions for PPD have been based on the premise that depression is the result of a woman's response to significant life events and stressors, such as difficulties related to labour, delivery, and parenting. Interventions such as continuous labour support including doula support have been shown to decrease depressive symptoms, while increasing self-esteem, exclusive breastfeeding, and maternal sensitivity to her child's needs (Ray & Hodnett, 2000; Scott et al., 1999). In addition, PHN home visits that focus on building trust, enhancing parenting self-esteem, providing anticipatory guidance, promoting preventive healthcare, and facilitating access to services have also been shown to reduce PPD symptomatology as measured on the EPDS for primiparous women at 6 weeks postpartum (Armstrong et al., 1999).

Although many different intervention approaches have been used to treat and support women with PPD, very little is known about the effectiveness of these approaches, or the manner in which they should be delivered. Which treatments, or combination of treatments, are most effective for whom? Perhaps most importantly, what do women think and feel about these interventions? For this review, only one study was found that used a qualitative methodology to determine women's own perspectives about the care they received (Beck, 1995b). In this phenomenological study, caring nurses were described as: having sufficient knowledge about PPD, using astute observation and intuition, providing hope, sharing valuable time, making appropriate referrals, providing continuity of care, and providing comfort through understanding.
If healthcare providers intend to develop interventions that are appropriate, acceptable, and effective, more research is needed that explores the phenomenon of women’s help seeking behaviour for PPD. What treatments do women use and why? How do their experiences of the care they receive help or hinder their recovery? What do they think would be most helpful?

The Concept of Recovery from Depression

Although the process of recovery from non-PPD has been well represented in the research literature (Chernomas, 1997; Peden, 1993, 1996; Schreiber, 1996, 2001; Steen, 1996; Wilkinson & Pierce, 1997), only one study describing the process of recovery for women who experienced PPD was found (Beck, 1992). In Beck’s grounded theory study that explored the meaning of PPD, loss of control emerged as the basic social psychological problem. Women coped with the experience of PPD through a basic social psychological process identified as “teetering on the edge” that consisted of four phases: encountering terror, dying of self, struggling to survive, and regaining control. Recovery was described as a slow and unpredictable process in which women mourned lost time and remained vigilant for signs of relapse. Although the process of non-PPD recovery is remarkably similar to the process described in Beck’s study, the influence of childbearing and parenthood on the development of depression is conspicuous by its absence from findings in these studies.

The Concept of Help Seeking for PPD

Although no definition for help seeking for women who experience PPD was identified in the literature, a definition developed by Gourash (1978) may provide insight into this process. In an extensive literature review and synthesis of research findings related to help seeking for emotional distress for male and female populations of varying ages Gourash defined help seeking as:

Any communication about a problem or troublesome event which is directed toward obtaining support, advice, or assistance in times of distress. Help-seeking thus includes
both general discussions about problems and specific appeals for aid. In addition it encompasses requests for assistance from friends, relatives, and neighbours as well as professional helping agents. (p. 414)

Only three studies examining women’s help-seeking behaviour for PPD were located for this review. Findings from these studies indicate that the percentage of new mothers who seek professional help for depressive symptoms ranges from 12% (Whitton & Appleby, 1996) to 40% (McIntosh, 1992; Small et al., 1994). Although little is known about when women seek help, and why, early findings suggest that women who do not seek help believe their symptoms are not severe (Whitton & Appleby); women who do seek help, only do so when their symptoms become too intense to cope with daily life (McIntosh). In a study that examined help-seeking behaviour for PPD, reasons identified by women for not seeking help were: feeling they had no one to turn to, feeling that depression is best coped with alone, and feeling that their symptoms were not severe (Small et al.). This study also showed that women who reported being depressed for 12 weeks or longer were more likely to seek professional help than women who experienced depression of shorter duration.

Some authors have suggested that women’s reluctance to seek help may be founded on the popular myth that equates motherhood with happiness and the idealisation of the “good” mother in which joy and other positive feelings are emphasized and unhappiness and other negative emotions are minimised (Lewis & Nicolson, 1997; Nicolson, 1999). Indeed, some women have reported shame and embarrassment in sharing their negative feelings with healthcare professionals and have expressed fears that someone would take their baby away (Mauthner, 1997).

Mothers’ perceptions about the cause of their depression, including whether they view the cause to be of internal or external origin, have been shown to determine the kind of help women seek, and from whom it is sought (McIntosh, 1992; Whitton & Appleby, 1996).
McIntosh found that most women believed the cause of their depression to be related to aspects of motherhood, including the never-ending demands of infant care, loss of freedom, frequent experience of loneliness and isolation, absence of assistance and support, and lack of time for oneself. Women who perceived their problem to be social rather than biological in origin saw no role for healthcare providers and as a result did not seek professional help.

For women who do seek help for depression during both postpartum and non-postpartum periods, research findings indicate that helping agents who listen to individual concerns, respect individuality, validate feelings, and provide reassurance that they are not going crazy are perceived as most helpful (McIntosh, 1992; Schreiber, 1996; Steen, 1996). Information, practical guidance, support, and treatment advice that are provided in straightforward, honest, and timely manners are considered beneficial. Family members, friends, and healthcare providers who are critical, judgemental, and patronizing or who misunderstand women's unique situations are considered to be unhelpful.

**Summary**

PPD is a serious and distressing condition experienced by a significant number of women and is linked to cognitive, emotional, and behavioural problems in infants and children, impaired mother-infant interactions, marital problems, and future episodes of maternal depression. Although there is general consensus in the literature that predictors of PPD include prenatal depression, troubled relationships with partners, previous psychiatric history, lack of social support, and occurrence of stressful life events, it may be naïve to seek, or expect to find, a simple explanation. In fact, it is more likely that the cause of PPD lies within the interaction of multiple physical, psychological, relational, and circumstantial factors. The development of PPD may also be influenced by the quality of nurturing and support available to a woman during her childhood and at the time of giving birth, and the meaning of childbirth for each woman within
the context of her own life (Holden, 1991).

Very few women seek professional help for PPD, and despite the fact that the postpartum period is a time in which most women have frequent contact with healthcare providers, very few women are identified as being depressed. Treatment approaches are generally based on either pharmacological, cognitive/behavioural, or psychosocial approaches and these interventions are most often designed and implemented by healthcare providers without input from women themselves. A striking gap in the research literature that examines treatment interventions is an almost total lack of reference to women’s experiences of the care they receive from family, friends, and healthcare providers.

Nurses play a vital role in the care of women and infants in the prenatal and postnatal periods. Clinical interventions and program planning that occurs within an environmental context in which women feel comfortable to seek the help they require, must be based on an understanding of women’s experiences. If women’s perceptions and beliefs are determining factors in the kind of help they seek, when and from whom, researchers must actively seek input from women themselves for “the people best able to guide us in the search are depressed women, because they are the ones who know about their paths into depression as well as the ways that lead out of it” (Jack, 1991, p. 23).
CHAPTER THREE: METHODS

Overview

Grounded theory as described by Strauss and Corbin (1990) was used to guide this research study. Grounded theory is a rigorous method of inquiry that challenges the researcher to seek understanding of human beings within a social context (Stern, 2001). Women’s experiences of seeking and receiving help for PPD are enmeshed within an intricate social network and therefore grounded theory, aimed at generating substantive theory about social phenomena, was deemed to be an appropriate research method. This study comprises the qualitative component of a four-part research project that explored the phenomenon of PPD. In this chapter the research design, participant selection, data collection, data analysis, rigour of analysis, and ethical considerations are presented.

Overall Research Design: A Four-Part Research Project

This thesis constitutes Study One of a collaborative four-part research project that investigated the phenomenon of PPD (see Appendix A). Study One is a qualitative research study that uses the method of grounded theory to examine the process of seeking and receiving help for PPD. Study Two is a quantitative longitudinal study that examines prevalence and risk factors of PPD to provide information that will contribute to the development of a predictive model of PPD. Study Three is a quantitative prospective study that examines the relationship between social and spiritual resources and the development of PPD. Study Four is an intervention pilot study testing the effect of peer support on depressive symptoms following childbirth. Because all four studies were conducted concurrently findings from Study One did not contribute to the development of the pilot for Study Four, however, these findings will contribute to the development of a larger intervention study to examine the effect of telephone-based peer support on PPD.
This collaborative research project was made possible through a unique partnership agreement between the UBC Faculty of Medicine, UBC School of Nursing, and Public Health Nursing services of the FVHR. Master of Nursing students completing their thesis requirements are the principal investigators for Study One and Study Three of the overall project. Site approval to conduct the four-part study was obtained from the board of the FVHR.

Research Design of Study One

A qualitative research approach, specifically grounded theory, was chosen for this study. "Qualitative research enables us to make sense of reality, to describe and explain the social world, and to develop explanatory models and theories" (Morse & Field, 1995, p. 10). This approach is particularly valuable when little is known about a phenomenon or when it is important to understand the meaning of an experience from the perspective of someone who is experiencing it. Although research is beginning to illuminate the nature, aetiology, and prevalence of PPD, little is known about women's experiences of seeking and receiving help for PPD. The researcher engaged in a focused exploration to elicit information about this phenomenon from the "emic," or participant's perspective (Morse & Field).

Help seeking for PPD is a process that evolves over time and therefore, grounded theory was deemed to be an appropriate approach to address the research question. The primary purpose of grounded theory is to develop an explanatory theory of human behaviour and is the method of choice when the construct being examined is considered to be a dynamic process (Morse & Field, 1995). In accordance with grounded theory methodology data collection and data analysis occur simultaneously and new participants are chosen based on an emerging theory (theoretical sampling) that is "grounded" in the data acquired from the participants themselves (Strauss & Corbin, 1998).
Study Participants and Setting

Participants

For the purpose of collecting rich data, purposive sampling was used to recruit women who had experienced PPD and who were articulate, reflective, and willing to share their experiences with the researcher and with other members of their particular focus group session. Data collection and analysis took place concurrently and as concepts emerged from the data new participants were chosen to maximize the opportunity to compare women’s experiences and to determine how the dimensions of their experiences varied. Eligible participants were 18 years of age or older and were able to read or understand English. Women who had experienced depression following a miscarriage, stillbirth, or adoption were excluded from the study. An effort was made to include women who were at different stages of recovery but not currently experiencing serious depressive symptoms.

Participant Recruitment

Participants were recruited into the study by several methods. In the late fall of 2000 advertisements were placed in a local newspaper to inform the community about the larger research project and how women could get involved. Posters were displayed in physician’s offices, health units, community facilities, shopping malls, and other locations accessible to mothers (see Appendix B). Additionally, local PHNs were encouraged to contact any clients who had experienced PPD and who might be interested in participating in focus group sessions.

Public health nursing managers from each community office designated one PHN to act as a liaison for the research project. These PHN research liaisons provided information to all staff about the project and fielded inquiries from the public and other healthcare providers. Although the research liaisons played a role in all four studies of the research project, their role in Study One was to make initial contact with potential study participants, gain telephone
consent for the researcher to contact participants, and submit names and contact numbers to the researcher (see Appendix C). Following an initial telephone interview conducted by the researcher, eligible participants were invited to attend one of six focus groups held during March and April 2001. Consenting participants were mailed an introductory letter of explanation (see Appendix D) and invitations detailing the place, date, and time of their particular session. Reminder telephone calls were made to each woman 3 or 4 days before the group session. As participants entered the study their names were entered into a recording system that tracked all participants throughout the study.

Setting

This study was conducted in the FVHR of BC. This health region consists of the communities of Mission, Chilliwack, Agassiz, Boston Bar, Abbotsford, and Hope that have a total population of approximately 250,000. In 1999, there were 3,200 births in the region (Fraser Valley Health Region, 2000).

Data Collection

Process of Data Collection

Focus group techniques were used to collect data for this study. The purpose of a focus group is to generate qualitative data that will provide in-depth information about how individuals think and feel about a phenomenon, thereby leading to increased understanding about people's attitudes, opinions, experiences, and perceptions. An advantage of focus groups is that the interaction of participants generally stimulates richer responses and allows for the emergence of new and valuable thoughts (Debus, 1993). Morgan (1988) suggests that “the hallmark of focus groups is the explicit use of the group interaction to produce data and insights that would be less accessible without the interaction found in a group” (p. 12). Focus groups should be small enough that participants have an opportunity to share insights but also large enough to encourage
diversity of perceptions: typically six to ten people (Aubel, 1994; Krueger & Casey, 2000; Morse & Field, 1995). Focus group moderators provide a structure and atmosphere that facilitates the sharing of private perceptions with others who have had similar experiences. Through this reciprocal dialogue participants may become more conscious of their own experiences and as a result the group as a whole may be more likely to find common meanings as they describe and explain these experiences. Focus groups are composed of participants who are similar to each other in a way that is important to the researcher (Krueger & Casey). Settings that are easily accessible, comfortable, private and non-threatening are most conducive to collecting rich data.

In this study the women were homogeneous in that they had all experienced PPD. The focus groups were held in private meeting rooms at local health unit offices within each of the four communities. These facilities were familiar and easily accessible to the participants. Funding received from the Registered Nurses Association of BC (RNABC), Mission Chapter was used to provide both reimbursement to mothers who needed babysitting services to attend the focus groups and refreshments that were served at the end of each session.

The researcher and a research assistant (RA), who was also a PHN, attended all six focus group sessions. The role of the RA was to take comprehensive notes, particularly related to group interaction, operate the tape recorder, respond to unexpected interruptions during the focus group session, and participate in a debriefing exercise with the researcher after completion of the session. The notes made by the RA contained pertinent observations including body language of participants indicating signs of agreement, hesitancy, or confusion (Krueger & Casey, 2000). These notes were used to help contextualize the sessions, verify congruence of verbal and non-verbal communication, and contribute to analysis of focus group techniques.

The researcher, who is trained in qualitative interviewing techniques, moderated all six 2-
hour focus group sessions. As participants arrived at the session they were greeted by the researcher, welcomed to the focus group session, given a consent form to be signed (see Appendix E) and a demographic information form to complete (see Appendix F). Participants were reminded that they could withdraw from the study at any time. To open the session the researcher introduced herself and the RA. The researcher informed participants about the plan for the focus group session and strongly encouraged everyone to maintain the confidentiality of other group participants. All participants were reminded that discussions would be audiotape recorded and that no names would be included in any reports.

A previously developed question guide (see Appendix G) was used to initiate and focus the discussion. Questions were open-ended, short, clear, easily articulated, and moved from general to specific. In addition, a list of previously prepared probing questions was used to encourage in-depth discussions and elaboration of themes. During the session the researcher directed the questioning route, tracked topics discussed, redirected the group and intervened at times when one member dominated the discussion, and probed for meaning. The researcher played an active role in the discussion by encouraging respondents to build on each other’s ideas but was mindful not to ask leading questions nor take control of the group interaction.

For the majority of the participants the chance to share their stories was taken on with gusto and the focus group discussions were lively. At every session women supported and encouraged each other and communed through tears and laughter. Although the researcher attempted to present a brief summary of the discussion at the end of each session we invariably ran out of time. In every case the researcher found that she had to interrupt the women to serve refreshments and close the session. Not surprisingly the discussion continued over coffee and cake and rich data were collected during this less formal time.

At the end of the session the researcher provided the focus group attendees with detailed
information the other three studies that are part of the larger researcher project. This
discussion was intentionally left to the end as Study Four was examining the effect of peer
support on postpartum depressive symptoms and it was deemed that this information might bias
the group discussion related to help seeking. Many of the women stated that they had found the
sessions therapeutic and expressed appreciation for the opportunity to share their stories. All the
women stated that this research was greatly needed and they were pleased that it was being
conducted in their health region. In addition, many of the participants expressed an interest to
participate as peer volunteers for Study Four. Participants were encouraged to briefly comment
about how they viewed the value of the session. Each participant was thanked for her volunteer
time and emotional investment in the session and given a specially designed thank you card that
included information about becoming a telephone peer support volunteer for Study Four

Risk is inherent in the act of sharing personal stories with others (Smith, 1995; Talbot,
1995) and the researcher was ever mindful of the risks these participants were taking. The
researcher made every effort to create a casual, friendly, and safe environment. Although several
of the women cried as they told their stories the opportunity to debrief over coffee and cake
became a time in which the women supported each other and gained back their composure
before leaving for home. At the close of every group session the researcher inquired about each
woman’s emotional well being and all participants reassured the researcher that they were
emotionally able to return home on their own.

A debriefing session between the researcher and the RA followed each focus group to
discuss observations and impressions. In addition, the researcher wrote detailed field notes
immediately after each focus group. These field notes, included reflections and ideas that were
used during the analysis to augment the focus group data. All interviews were transcribed
verbatim as soon as possible and checked for accuracy with the audiotape. All pages of the
transcript were numbered sequentially and contained the focus group number and participants’
code numbers. A data filing system was developed to manage and retrieve data.

Data Collection Tools

For this study, a demographic form was developed to describe the study participants. To
ensure that the form was quick to complete, easy to understand, and comprehensive enough to
provide a clear description of the participants, three women who had experienced PPD and three
experts in the field were asked to provide comments and suggestions. A letter was sent to each of
these six reviewers (see Appendix H) requesting that a feedback form (see Appendix I) be
completed and returned to the researcher; the feedback received was used to make revisions to
the demographic form before it was administered to study participants.

Data Analysis

Process of Analysis

Grounded theory uses constant comparative analysis in which each piece of data is
compared to every other piece of relevant data. Categories, or conceptual elements of theory and
their properties, are identified through the fundamental analytical process of coding (Corbin &
Strauss, 1990; Morse & Field, 1995). Using these techniques, the focus group data were
compared throughout the data collection period to identify themes and to inductively derive
patterns of help seeking behaviour. Demographic information was used to describe the study
participants. Observational field notes recorded by the RA, memos, and researcher journal
notations were transcribed verbatim, and examined and interpreted in minute detail to identify
patterns of help seeking behaviour.

As the transcripts became available, the researcher analyzed the data using first-level
coding. First-level coding is also known as substantive or open coding and involves a process in
which interview transcripts are analysed line-by-line. During this process important words and
phrases were highlighted and descriptive code names representing common concepts were written in the right-hand margin (Morse & Field, 1995). Common codes began to emerge from the data and were clustered according to similarity or dissimilarity of content. For instance codes such as “wanting to hide,” “not knowing what it was,” “being a basket case,” “wanting to be normal,” “worrying about recovery,” “being given pat answers,” and “watching myself” were some of the initial codes identified in the data. At this stage, early memos documenting initial impressions, thoughts, and directions were written. These memos provided a glimpse into the help seeking process and set the stage for the next step in the coding process (Strauss & Corbin, 1998).

In the second step axial coding was used to categorize, recategorize, and condense all first-level codes and identify the relationships of the properties of the categories. For instance, initial codes were grouped into such categories as “experiencing it,” “dealing with it,” “trying to explain it,” “being afraid,” “experiencing loss,” “peaking,” “calling it by name,” “asking for help,” “feeling better,” and “reflecting on recovery.” Subcategories were identified and were related to categories through the coding paradigm of conditions, context, strategies, and consequences and the researcher asked questions of the data such as, what, when, where, with whom, how, and with what consequences (Corbin & Strauss, 1990). At this point relevant paragraphs from each transcript were cut and pasted onto pages with category headings. Using this grouped data, relationships between categories were illuminated through the use of visual diagrams and mapping. As theory emerged from the data, relevant issues were incorporated into the next focus group interviews. Memos taken at this stage in the analysis process were used to document theoretical ideas, insights, and interpretations (Morse & Field, 1995).

As each woman told her story it became obvious that the process of help seeking was intricately connected to the trajectory of the depression experience itself. Each help seeking
category was matched to a second category that illustrated the trajectory of the depressive symptoms. The three new categories emerged: (1) falling apart / waiting to be rescued, (2) knowing what it is / giving in and opening up, and (3) feeling better: an uneasy peace / tuning-in to self. At this point the transcript data were reorganized and grouped according to these new categories. New diagrams and maps were constructed that provided a structural framework to view the process of help seeking as it related to the course of the depressive experience.

Selective coding was the final step in the coding process. In this process all categories were unified around a core category representing the central phenomenon of the study (Corbin & Strauss, 1990). In this study the core category was identified as breaking the silence. The memos at this stage reflected the complexity of thought of the emerging theory (Strauss & Corbin, 1998). As concepts began to show relatedness the literature was again reviewed to generate new questions and problems. For instance concepts such as transition to motherhood, loss, recovery, and relapse became issues that were pertinent to a broader understanding of the phenomenon. As the documents and memos were analyzed and sorted the researcher achieved saturation with no new information being identified that would indicate a new category. Through this grounded theory process an explanatory model of women’s experiences of seeking and receiving help for PPD was developed.

Rigour of Analysis

Qualitative inquiry appreciates the view that there are multiple realities to human experience and the researcher is entrusted to report these perspectives as clearly as possible (Morse & Field, 1995). Critical attention to rigour that attempts to prevent error of either a constant or intermittent nature (Morse & Field) ensures the trustworthiness of research findings and is achieved by meeting the objectives of credibility, transferability, dependability, and confirmability (Beck, 1993a; Sandelowski, 1986).
Credibility

The criterion of credibility in qualitative research refers to the confidence one has in the truthfulness of the findings and is achieved when the findings, conclusions, and recommendations are supported by the data and when there is internal agreement between the investigator’s interpretations and the actual evidence (Beck, 1992). Credibility measures the vividness and faithfulness of the phenomenon being explored and is attained when people who have experienced the phenomenon can describe it as their own (Beck, 1993a). In this study the researcher maintained a rigorous adherence to analysis of the data to ensure that coding categories reported, and examples used, were representative of the data as a whole. In addition, the researcher deliberately tried to discount or disprove conclusions reached throughout the data analysis process. As data analysis progressed, beginning conceptualizations were verified with existing literature and submitted to a member check by taking this data back to the participants for their critical consideration. In November 2001 an ‘Appreciation Night’ was held for the focus group participants and the peer support volunteers from Study Four. Women who have experienced PPD are considered the best individuals to confirm the fit of the categories and therefore each participant received a preliminary diagram illustrating the help seeking process. Several of these women discussed the findings with the researcher who then used this new information to modify the coding scheme. In addition, attendees were encouraged to provide feedback by email or letter. One woman carefully reviewed the concept diagram and mailed her thoughtful feedback to the researcher. As conceptualisations emerged from the data, the researcher sought advice and suggestions from her thesis committee members, nursing colleagues, and experts in the field.

Fittingness

Fittingness is the criterion used to determine whether findings can be applied in other
contexts or settings or with other groups (Beck, 1993a). In this study fittingness of the findings was achieved through thick description developed from the rich data provided by these participants. Thick description included details of the affect of the participants, the relationships of women within their social context, and the backgrounds each woman brought to the discussion. In addition, interpretation of the data included references to the tone of voice, feelings, and meaning of the situation for all participants. Adequacy of the data was ensured through a process of data collection that continued until saturation occurred (Morse, 1994). Purposeful sampling, in which key informants were selected according to the theoretical needs of the study ensured the appropriateness of the data collected. For instance, as the themes related to help seeking at the point in which women were feeling better emerged from the data, the researcher purposely recruited women to the groups who were further along in the recovery process and able to share this experience.

Auditability

Auditability refers to the ability of another investigator to follow logistically the process and procedures used by the researcher (Beck, 1993a); this process is enhanced using an audit trail (Morse, 1994). For this study, the researcher developed a comprehensive system of recording, kept detailed and dated field notes and analytic memos as the themes emerged. In this way the analytic process was tracked. The final report for this study describes the reason the researcher decided to do the study, the purpose of the study, information about the participants and how they were recruited, the setting in which the data were collected, and explicit data collection and analysis procedures. Quotations from the participants were used to illustrate and verify category selection and assumptions were made explicit before engagement in data collection.
Confirmability

Confirmability refers to freedom from bias in the research procedure. Confirmability is achieved when the researcher can maintain prolonged contact with the informants by using long periods of observation and identify personal biases through the use of memos and consultation with other researchers (Morse & Field, 1995). In this study the researcher spent approximately 3 hours with each participant, including an initial telephone interview to determine study eligibility, and the focus group session itself. Although it is impossible to eliminate all bias, considerable time was spent reflecting on previously held values, beliefs, and perceptions about childbirth and parenting, as well as personal experiences both as a mother and a PHN. Reflective memos and notes were used to minimize bias.

Ethical Considerations

The UBC, Behavioural Science Screening Committee for Research and Other Studies Involving Human Subjects reviewed this study to ensure that the university’s ethical requirements for protecting human rights were met (see Appendix J). Women were recruited into this study through a variety of sources and permission was obtained for the researcher to contact interested participants to provide a detailed explanation of the study. Women who agreed to participate and met the inclusion criteria were asked to sign a consent form as they arrived at the focus group session. The researcher informed all of the women that they could withdraw from the study at any time with no effect on their use of health services now or in the future.

The participants were aware that their participation in the focus groups was voluntary and that they were not required to answer any questions that made them feel uncomfortable. All information collected was kept strictly confidential and was stored in a secure filing cabinet. All consent forms, addresses, and telephone numbers were kept in a separate secure filing cabinet. Any identifying information will remain confidential and will not be used in any written report.
of the study. The data records were kept on a computer hard disk and stored in a secure file with password access. A backup copy of all interview data was kept in a separate location. Access to the data was limited to the researcher, the RA, and the thesis committee members. A summary of the study findings will be made available to any participants who request it.

Due to the sensitive nature of the discussions and the risk women took to confide in the researcher and focus group participants, the researcher remained vigilant to signs of distress throughout each interview session. In addition, a plan was in place to call a family member or friend in the event that any participant became too emotionally upset to return home on her own. If no support person could be contacted the researcher was prepared to drive the participant home and to ensure that she were not left alone. The researcher used a flexible approach in the interview process when participants were observed to be crying or upset. Although many of the participants cried during the sessions, the universal response from other focus group members was sympathy and encouragement. In addition, the half hour refreshment period at the close of the session provided a debriefing time for participants as well as an opportunity for the researcher to assess each participant's mood.

Summary

This study constitutes Study One of a four-part research project that was conducted in collaboration with Public Health Nursing Services of the FVHR and UBC from 2001 to 2002. Study One consists of a qualitative study using a grounded theory approach. Women who had experienced PPD and who were considered to be good informants, were invited to participate in one of six focus group sessions. Narrative data from the focus group sessions were analyzed using the constant comparative techniques of grounded theory. As data were analyzed theoretical sampling was used in which further participants were recruited according to the emerging theory. Open coding, axial coding, and selective coding strategies were used to identify the core
category. This core category represented the central phenomenon of the study. Standards of rigour were maintained throughout the process of sampling, data collection, and data analysis. All ethical requirements for protecting human rights were met.
CHAPTER FOUR: FINDINGS AND INTERPRETATION

Overview

The findings from this grounded theory study consisted of a substantive theory of help seeking for women with PPD. The merit of a substantive theory “lies in its ability to speak specifically for the populations from which it was derived and to apply back to them” (Strauss & Corbin, 1998, p.267). Informants who participated in this study represented a particular subset of women who experienced depression following the birth of a baby and who were willing to respond to a recruitment poster or personal invitation from a PHN with previous knowledge of their depressive experience. Findings from this study are limited to the experiences and perspectives of this particular population at a particular time and are not generalizable to other populations. The substantive theory provides new insight into the process of help seeking for depression as it occurs over time and within the context of motherhood.

In this chapter the study findings are arranged in the following order: description of the participants, characteristics of focus groups, the context of motherhood in which PPD occurs, identification of the core category, and a detailed description of the phases of the help seeking process. The three phases of the help seeking process are identified as: (1) waiting to be rescued, (2) giving in and opening up, and (3) tuning-in to self. Findings from this study have particular relevance to mothers who experience depression in the postpartum period and may provide guidance to families, friends, and healthcare providers who care about, and for, these women.

Description of the Participants

In this study 30 women shared their personal stories of depression following the birth of one or more of their children. All of the participants lived within the FVHR of British Columbia, and ranged in age from 23 to 50 years. Twenty-eight women were Caucasian and two women were of Aboriginal heritage. All of the women in this study were high school graduates, 20 had
attended trade school, college or university and four of these women were university graduates. Seven women had one child, 15 women had two children, and eight women had three or more children. Their children ranged in age from 2 months to 28 years. The experience of PPD for six participants occurred 15 to 28 years ago. The remaining 24 experienced PPD within the last 7 years. At the time of the depressive episode all of the women in this study were living with a male partner.

Twenty-two women in this study had one episode of PPD and eight women had two episodes. Of the 22 women who had a single episode of depression, seven were primiparas and 15 were multiparas. Of the 15 multiparous women, four had depression following the birth of their first child, 10 had depression following the birth of a second child, and one had depression after the birth of her third child. Two of the women who had one episode of depression, experienced a second depressive episode several years later that was unrelated to childbirth. Six of the eight women who had two episodes of PPD had two children, one woman had three children, and one woman had five children. Eleven women reported the onset of symptoms within 4 weeks of delivery. Three of these women noticed sudden onset almost immediately after delivery and eight others reported symptoms within the first 4 weeks of giving birth. Fourteen women developed symptoms between 1 and 6 months postpartum, while five women were unaware of any depressive symptoms until their baby was over 6 months of age. Although all of the women in this study identified a time in which symptoms of PPD began, it is interesting to note that on reflection, 10 of these women wondered if they might have been depressed during pregnancy.

Although most of the women who participated in the focus groups stated that their depression had largely resolved, nine were taking antidepressant medication at the time of the interviews, and all of the women expressed nagging doubts about the extent of their recovery.
Women spoke of depression as a life changing experience that was complicated by a sense that depression “is always there behind you - going to tap you on the shoulder.” Although all of the study participants defined their condition as PPD and had responded to a recruitment advertisement that specifically identified PPD as the phenomenon of interest, many reflected on the possibility of having had a previous unrecognized depressive experience.

The Focus Groups

In total, 47 women inquired about participation in this study and 40 women were deemed eligible after telephone interviews with the researcher. A total of 30 women attended one of the six different focus group sessions. Of the 10 women who did not attend the sessions, four were unable to coordinate dates and times, three cancelled because of illness of self or child, and three did not show up on the night scheduled. In this study one focus group consisted of four participants, four groups consisted of five participants each, and one group consisted of six participants. The women who attended the focus group sessions participated fully in lively discussion and story telling that contributed to the generation of rich interview data.

Although some of the women had been contacted personally by a PHN and encouraged to participate in the study, the majority of the participants read about the focus groups from newspaper advertisements or posters displayed in the community. The women described intense emotional experiences as they read the advertisements and many deliberated for several days before inquiring further. One woman described this highly emotional experience as follows:

When I saw the ad my heart started beating fast - and I know I am not over it yet - and know I still have a long way to go. And when my husband saw the ad he cut it out for me. I didn't cut it out myself. I saw it. It was in the back of my mind. And he cut it out for me and he said, “Did you see this?” And I said “Ya.” And he said, “What do you think?” And I said, “I think it would be really good for me to deal with it more, you know.” So my being here just proves that I am on the road. And I am just recovering still.

The participants showed great courage and strength as they shared their personal stories and innermost feelings. It was apparent from the outset that many of the participants felt a sense
of kinship within the group, believing that only others who had experienced a serious depression within the context of being a new mother, could truly understand their suffering. It was remarkable to observe the compassion expressed by the group members as each woman told her story. As the women “opened up,” tears were shed and a box of tissues made its way around the table. On many occasions, audible coos and soothing sounds provided a symphonic background for the women’s voices. On other occasions, uproarious laughter filled the room creating caring and empathetic connections within the group. As each session ended, several participants exchanged names and telephone numbers.

Each woman was aware that telling her personal story would provide data that would assist in the development of new knowledge and understanding about the phenomenon of PPD. For all women who attended the focus group sessions the stated goal was to help others, a sentiment outlined below:

When I saw the story in the newspaper about this, I thought, that's a chance for me to voice my opinion as to where I want more help and also a chance for me to help somebody else. Because I know when I was going through it, it was awful. I mean you just feel like you're so alone and that nobody else knows what's going on and if I could go to somebody and say, “You're not alone, I've been there, done that, and I survived... The Context of PPD

The experience of childbirth, and beliefs about the motherhood role, are shaped by social and cultural norms embedded in the daily lives of women. PPD presents a tragic irony. For the women in this study, their hopeful anticipation of childbirth and motherhood stood out in sharp contrast to their actual experiences. The women’s feelings of hopelessness, despair, and guilt reflected an intense sense of loss related to all aspects of childbirth and motherhood. With deep sadness the women described how they had deprived their children of a joyful mother or had been the worst mother in the world because they were sick. The women viewed the experience of PPD as something completely different from the experience of depression at other times in
people's lives.

The Core Concept: Breaking the Silence

As each woman shared her unique experience a theory of help seeking for PPD emerged from the data. *Breaking the silence* emerged as the core category and describes women's journey from silence to voice. In this substantive theory, the process of help seeking is understood in light of women’s perceptions of their experience of depression and the context in which this depression occurs. Each phase of this process consists of help seeking behaviour that reflects women’s internal analysis of their situation at particular times. During the first phase of the help seeking process the women perceived that they were falling apart and responded by *waiting to be rescued*, a time in which they suffered in silence. Increasing symptoms and feelings of being out of control brought these women to a crisis point in which they were finally able to call their depression by name. This act of recognition provided new insight as to the nature of the problem and prepared them to reach out for help. *Giving in and opening up* constitutes the second phase of the help seeking process. During this phase the women revealed their depression to others, sought different kinds of help from a variety of sources, and accepted, rejected, or modified help that was offered. As the symptoms diminished the women began to feel better. Feeling better represented an uneasy peace however, for they felt compelled to monitor what they perceived to be, a tenuous recovery. The third phase of the help seeking process is identified as *tuning-in to self*, and describes a time of reflection in which the women sought meaning in their experience. As the women integrated the experience of PPD into their daily lives a new sense of self emerged in which women found the strength, the courage and the words to break the silence. Recurrent episodes, perceived by the women to be triggered by the birth of another child or a stressful life event, meant that some experienced this process more than once.


**Figure 1.** The phases of the help seeking process.

**Waiting to be rescued** → **Giving in and opening up** → **Tuning-in to self**

- **Falling apart**
  - **Starting to feel normal**
  - **Reaching the end of the line...**
  - **a turning point**

- **Silence** → **Voice**

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**The Phases of Help Seeking**

**Phase I: Waiting to Be Rescued**

Waiting to be rescued is a term that best describes the help seeking and help receiving process in Phase I. This is illustrated by one woman who stated, "And I even said to him, 'I expect you to be my knight in shining armour and come and rescue me and you're not'. I was really waiting to be rescued. I really was." This phase began with the onset of depression that was described as *falling apart* followed by an internal struggle in which the women made valiant attempts to protect themselves and their babies. During Phase I the women perceived that they had *nowhere to turn* and therefore did not seek help. Not asking for help was seen to contribute to their distress, as described by one woman, "I didn’t ask for help. I didn’t ask for help. That is why I was falling apart.” As depressive symptoms increased and the women felt increasingly out of control they reached a crisis point in which they could no longer tolerate their situation.

*Reaching the end of the line* represents a moment of recognition in which the women were able
to call their depression by name and reach out for help.

Falling Apart

Falling apart was a universal theme throughout the discussions. Although it was apparent from the outset that something was wrong, the women were unable to define their problem or find words to express their suffering. Overwhelmingly, these women responded with fear and shock, and experienced a terrifying sense of being separated from self. The onset of depression was gradual for some but hit with breathtaking suddenness for others. Depression was frequently perceived as an attack from a malevolent force over which the women had no control and for which they were completely unprepared. One woman portrayed this experience in the following way: “I am Miss Perky. Miss Happy. Miss I Can Do It All… and this thing hit me like a brick wall. I did not see it coming out of anywhere.” Some women actually personified this force and spoke to it as if their words could drive it away. For instance, one woman expressed a sense of impotence and shock as she confronted this force: “I knew some days it was stronger than me. It was winning. That’s when it really hit me. ‘Like, okay don’t do this to me!’ I was so shocked.”

There was a remarkable consistency in the stories told by the women who experienced a sudden onset of depression. The day, time, and place of the “attack” were described in vivid detail leaving every woman with only one question... “What is going on?” One woman’s vivid story illustrates the suddenness of this attack:

It just hit me. I was sitting on the couch feeding my baby, and my husband was sleeping on the other couch. At 10:16 on a Friday night I was watching 20/20 and these two guys were arrested and they were, maybe they were scary to me or something, they were quite young maybe fifteen or seventeen, and maybe that somehow triggered it. But all of a sudden it just, there were just things happening in my head. Just weird nervous feelings, and I just stood up and I told my husband you know like “I’ve got to get out of the house.” And it was raining out. And it was in March. So it was pretty cold out. So I went outside in the driveway, and I’m walking up and down the driveway, and I’m just like, “What is going on? I don’t understand.”

The length of time from onset of symptoms to the recognition or detection of depression
varied for the women depending on a multitude of factors, however, knowing something was wrong and not knowing what it was or how to explain it, was a universal experience. One woman described this inability to define her problem and communicate it to others:

And people didn’t know. I didn’t know what was wrong. I just knew that I wasn’t sleeping. I was having panic attacks all the time. I felt hopeless. I felt like I was in a deep dark pit and somebody would have to come with a spatula and scrape me off the bottom. Because I just felt like I was in this big deep hole. Nobody understood. People tried, but I couldn’t tell them what was wrong.

Finding the words to describe the experience of depression remained elusive to the women and their families. One woman put this phenomenon in comical terms that rang true to the other women in her focus group when she referred to PPD as the “P” word:

And my husband was very concerned for me. And he kept saying, “I don’t think the doctor knows what is going on.” And he kept saying that. You know he kept saying that. But you know, we never said the “P” word.

Thus, not knowing what it was, or how to explain it, prevented these women and their families from seeking help for depression. Although many of the women recalled hearing the term PPD, they did not associate this term with their own situation, believing that PPD is when “you want to kill your baby.”

Physical symptoms signalled to the women and their families that something was wrong. The women described problems with sleeping, eating, and a general feeling that their body was shutting down. Many women and their families did not recognize the symptoms as depression believing that problems with eating, sleeping, and fatigue are normal after childbirth. As the depression deepened, however, many women found that they were unable to sleep at all because of intense feelings of anxiety and panic and an accompanying fear of leaving the baby unattended. As described by one participant, some women worried that if they fell asleep they would never wake up:

I knew something was wrong when I couldn’t sleep. I wouldn’t allow myself to sleep. People would say, “Oh go rest.” And I remember, I was in the bed - and I was sitting up
in the bed like - "I'm going rest, rest," yeah, like that - and I couldn't lie back down, I couldn't. I wouldn't even allow myself to. I don't know what it was. It just felt as if I was guilty to try and rest. Like I should be caring for my baby. Like other people shouldn't be. I just felt that I never got any sleep. It seemed like days or maybe weeks on end that I wouldn't allow myself to fall into a sleep.

Another vividly explains her fear of falling asleep:

I was afraid that I would die if I fell asleep. Because I would get these really strange feelings, like my head would get this tingling sensation that you get when your leg falls asleep. And I was getting it in my head. And I was afraid to let myself go that far because I was afraid I would never wake up.

As the depressive symptoms increased the women also experienced problems with eating. Some women described being physically unable to swallow their food while others described such things as “starving myself,” “not eating for the first 3 months at all,” “throwing up anything I tried to eat,” and “losing weight.” The women described feelings of overwhelming fatigue and expressed sorrow and resentment that their partners interpreted their behaviour as laziness. The feelings of not being able to get going or get organized were compounded by feelings that others did not understand.

In addition to physical symptoms, the women described profound emotional distress that left them feeling overwhelmed, guilty, inadequate, and misunderstood. Many perceived these feelings to be related to a difficult delivery, problems with breastfeeding, or having an inconsolable child. This perception was illustrated by one woman who stated, "One of my contributing factors was my ineptness at breastfeeding, along with all these other things that you're supposed to be doing as a mother.” Another stated, “Here comes this child who is never happy, crying all the time. I can’t console him. I can’t breastfeed - lots of different emotions. And I really felt inadequate as a mother because I could not console this child.”

Although all but one of the women had planned to breastfeed, and believed it to be the best thing for the baby, almost one half described problems with breastfeeding. Some described the experience as being a total disaster and complained of being pushed into breastfeeding.
Within the context of depression, one woman described her ambivalence about breastfeeding and the pressure she felt from others:

And so here I was at four o'clock in the morning and I couldn't feed him. I didn't know what was wrong. My husband was pro breastfeeding and I was kind of "Right, well I will do it because it is the best thing for the baby" but I didn't really have my heart in it from the beginning. I don't think I did, but I knew I had to do it. I wanted to do it for my baby.

The women also experienced cognitive symptoms such as inability to concentrate, feeling scatterbrained, and having crazy thoughts and delusions. For many, these feelings were accompanied by sudden and terrifying panic attacks and a preoccupation with thoughts of dying or killing themselves or their children. One woman shared these terrible thoughts with other women in her focus group: "It scared me having those thoughts of killing myself, and killing my daughter, and being left alone with her especially at night. And having those nightmares at night that I was dying or my husband was trying to kill me!" Thoughts of suicide that invaded these women's minds were especially disturbing and many made mental plans about how to kill themselves. Thinking about "ending it" by driving off the side of the road was a common theme in the women's stories. In every such instance, however, the women were convinced that it was only because their children were in the car with them that they did not follow through with these plans. One woman wept as she described a pact she made with herself during the height of her depression, "I am not going to kill myself and if I ever feel that I am so close I will commit myself to the hospital because I want to be there for my baby and my husband." Of all the symptoms experienced by the women these distorted thoughts and delusions were the most distressing. One woman described the need to rid herself of these terrible thoughts and to think normally:

I wanted normal back in my life. But I couldn't explain it... I realize now I couldn't explain what normal really meant because normal to me was normal thinking. And every time I would cry my mom would say, "Well, what is wrong?" and I would say, "I don't know, I don't know. I just want things to be normal. Why aren't things normal?"
Twenty-three women described intense panic attacks that were accompanied by fears of dying, going completely insane, or having a heart attack. The following statements illustrate the power and magnitude of these attacks:

I had anxiety so bad that I went from just absolute agitation to panic attacks to fits of rage. I thought, "There is something wrong with me." I was absolutely... I mean I felt that I was possessed.

My breast milk went away and like for 2 days, because she wouldn't eat again and that is when I went over that edge. "Ah, I can't handle this." I was like so stressed out about her and within a few days of that I woke up just with a panic attack. I had never had one before and my heart was pounding and I started shaking and I couldn't sleep all night and it was like so terrible and for me that is when it manifested. It was like anxiety and insomnia, really bad for 5 weeks.

Women who experienced panic did not associate this symptom with depression and recalled being stunned when they were diagnosed with PPD. The experience of being wound up tighter than a drum did not match the common belief that a person with depression presents as someone who "never takes a bath" or "mutters on the street." As one woman stated, "I was Martha Stewart when people came to visit the baby... but I had anxiety sky high. So I didn't think it was depression I thought it was just ... I didn't think." The panic felt by these women was often expressed as an excessive anxiety over the health of their new baby. Reluctance to let anyone else care for their baby, including their partner was a common theme. One woman reflected on these feelings:

When I had my daughter you know, the first 3 months were horrible. I couldn't leave her with anybody. I believed I was the only person who could take care of my daughter. Even my husband - I couldn't leave her with my husband. So that was part of the depression I think, this psychotic feeling that no one can take care of my baby.

Of the 23 women who experienced panic attacks, 18 took antidepressant medications, two refused medications recommended by their doctor, one did not tell her doctor about her feelings of panic, one woman's doctor felt counselling was a preferential treatment, and one described her doctor as "being lost about what to order." Although many women described side effects related
to the antidepressant medications, all but one found the treatment to be helpful.

Fear and loss were common themes. The women were overwhelmed by a multitude of fears, including: fear of what others would think of them, fear that their babies would be taken away, fear that employers would find out about their depression, fear of dying, fear of harming themselves or their children, fear that they were going crazy, fear that they would never get better, fear that they could pass depression along to their children, and fear of being possessed. Losses related to loss of confidence in the motherhood role, loss of identity as wife, loss of control, loss of hope, dreams and expectations, loss of memories, loss of self, and loss of relationship with God. One woman described her separation from God in the following words, “I felt spiritually alienated. I felt that God had given up on me and I couldn’t reach Him. To me that was a real worry because I am a spiritually sensitive person.” Although women tried desperately to explain the feelings of loss of self to others, their words were inadequate. Phrases the women used to describe this experience included: “you were there... but you weren’t there,” “not being myself,” “sitting outside yourself,” “having no clue who you are,” “I wasn’t me,” “not feeling normal,” and “believing I was somebody different.”

Trying to Survive

Trying to survive was the primary strategy used by women who were falling apart. This inner struggle consisted of four key strategies: keeping the secret, not wanting to think about it, trying to analyze it, and giving off signals. Although this internal struggle made women feel that they were “doing something” to cope with their distress, this strategy only moved women into isolation and family members into frustration and despair. PPD occurs within the context of social relationships and women’s systematic attempts to retreat into silence further amplified their distress.

Keeping the secret. Keeping the secret served a very specific purpose. As women fell
apart, they experienced terrifying thoughts and feelings about death or harming themselves or their babies. How could these horrific thoughts be put into words? Who could be trusted with such terrible information? In a supreme effort to protect themselves and their babies, these women stopped communicating with others. Profound feelings of failure and inadequacy demanded absolute secrecy. One woman tearfully expressed this need to keep quiet:

I thought - I am no good. Like, I wanted to live up to all these expectations that people were telling me and I couldn’t, so I had to hide it. I had to hide the depression. I had to put on a happy face and, you know... No one is going to know this is happening. I just felt like I was just no good at this. I am not a good mom, and I couldn’t let anybody know that.

The women became adept at hiding their feelings and described their behaviour as “putting on a façade,” “putting on a brave face,” “hiding myself away,” “turning into self,” and “pushing everyone away.” One woman described the monumental effort required to put on a face for her husband:

So I was home a lot. I made sure I got dressed before my husband got home from work, though, everyday. I did that. I didn’t want to. I made myself do that. So by the time five o’clock came around I had to stop crying and get dressed. That was my goal for the day.

The women were unlikely to reveal their secret to healthcare providers. During the early postpartum months the women attended numerous doctor and health nurse appointments related to baby care. These appointments focused on regular checkups, immunizations, and information or advice on feeding, colic, or other health issues. Maternal health assessments were generally focused on women’s vague complaints of “not feeling right” or other physical concerns such as insomnia or headaches. Unfortunately, the continual need for women to hide their depression left healthcare providers in the dark as to the serious nature of their depressive symptoms. The women reported being embarrassed and ashamed to tell their doctors how bad they were feeling. One woman’s description highlights the sense of shame these women felt when asking their doctor for help: “It’s almost like you are lowering yourself to go in there and tell him, ‘Hey, I am
falling apart.' You are destroying the whole image, which is the worst thing to do."

Two of the participants provided keen insight into their need to keep their secret, even from themselves. These women believed that saying the words out loud gave legitimacy to their depression and this was something they were not prepared to do during this initial period. One woman stated that ‘you think bad thoughts in your head and then you’re like okay – that’s really bad --and then if you say it out loud it is so much worse. That’s why you don’t talk.” Another woman related that:

My family didn’t hear from me and that was the key that there was something wrong. We didn’t live around anybody. I basically shut off communication for months because I didn’t want to... even to this day when I hear myself speak about something I am going through that is really painful -- when I hear my words it is too real. If I say the words it is very real. Until I am able to say it - I am not ready to talk to anybody about it, and sometimes that takes a long time.

Not wanting to think about it. A common theme throughout the interview data was the need for women to keep their minds busy so that they did not have to “think about it.” Delusions and distorted thoughts related to harming themselves or their infants became intolerable. Attempts to hide from these terrifying thoughts by shutting off communication and isolating themselves from others were often not sufficient to ease the pain. The women were not prepared to confront these thoughts and feelings and consequently, “not thinking about it” (meaning depression) or as one woman put it, “filling the void,” became a preferred strategy. The women’s descriptions of “constantly filling my mind with something” “keeping my mind busy,” and “pushing it to the back of my mind,” describe these attempts to ward off panic attacks and to chase distorted thoughts and delusions away. One woman’s description illustrates this strategy:

I think that is sort of like the fear of going home because I didn’t want to be in an environment where I could just sit there and think about it and experience it. It was much better to be at school burying it.

Trying to avoid these panic attacks and distorted thoughts prompted several women to make significant life choices including having another baby, enrolling in school, going back to work,
buying a new house, or quitting a job. Sadly, two women decided to leave their partners during this time. Frequently, the women cycled between trying to hide and trying to keep busy as described in the following description:

Sometimes you felt guilty because it felt like I was lazy during it because I had no energy. I didn’t want to do anything. And other times you’d be totally like, “I’ve got to do this and get focused and completely obsess about getting something done and then completely fall apart and not want to do anything again.

“Not wanting to do anything” and obsessing about “getting something done” appeared to serve the same purpose: burying feelings that were too difficult to confront, thereby avoiding what one woman described as the “big crash.”

Many of the women engaged in what they defined as “if-only” thinking. As the women tried to survive they spent considerable time trying to convince themselves that everything would be better if only they could get some sleep, if only the baby would stop crying, if only they could go back to work, or if only the baby was a little older. One woman described this “if-only” thinking in the following way:

The busier I could be the better I was. And then every two years I just kept having babies because I just thought that was the only thing I could do to keep myself busy you know. I was always thinking everything would be absolutely wonderful if only, you know. I kept trying to fill it with if I could only do this or if I could only move back to Nanaimo. There were so many if-only’s. Ya, so I just kept trying to fill my life with the if-only’s.

Trying to analyze it. As the women tried to survive they attempted to analyze why they were falling apart. All of the women in this study voiced the assumption that their depression was intricately connected to the birth of their baby and the new demands of parenting. Although four women voiced concern that early childhood experiences of trauma or abuse may have left them vulnerable to PPD, the overwhelming majority attributed their depression to such factors as having a difficult delivery, having an ill child, or a child that cried incessantly, not getting enough sleep, believing it is just the baby blues, being away from family, feeling lonely and isolated, having problems with breastfeeding, stress, the time of the year, or having a husband
who worked long hours. Many women saw themselves as prime candidates, who were “prone,” “predisposed,” or “set up” for depression through heredity or life circumstances. One woman tearfully described her feelings about being weak and vulnerable to evil as she stated, “But, like depression - there is a chemical side and you are depressed. But then I think you get attacked. Like, in your low points, like the evil in this world knows – I am going to aim for her.” Many of the women believed in a hormonal cause for their depression making statements such as, “I was isolated but that didn’t cause it. It was caused by a chemical malfunction” and “I do believe now that it is a hormone thing that you can’t control.” Hormonal shifts at times of childbirth and at the discontinuation of breastfeeding were seen as precursors to depressive symptoms and several women expressed concern that depression could return during menopause.

The women’s experiences of depression during pregnancy varied, and while some women felt that their depression was more pronounced during pregnancy, others were surprisingly free from depression at that time. In fact, several women were thrilled to be pregnant again because it brought almost immediate relief from their depressive symptoms. For instance, one woman said, “When I am pregnant I am perfect, chemically perfect. I am the perfect person when I am pregnant” while another stated that “all the symptoms that I had disappeared when I got pregnant. I felt back myself.”

**Giving off signals.** The need to keep the secret prevented the women from communicating their feelings in words and consequently, the women knowingly, or unknowingly, resorted to giving off signals. Family members, friends, and healthcare providers were then expected to use intuition and guesswork to interpret these signals. One woman described a scene in which her doctor kept asking how she was doing. When asked why she thought he was so persistent she replied:

Well, I would suspect he had seen some signs in me. I was losing weight at a fast clip and just probably didn’t look very healthy because of the sleep deprivation or whatever. But
he just sensed something was wrong. He could tell. And I knew in the way he was asking me, he couldn't come out and say it - like I would have to admit it first, but I just wouldn't. I wouldn't. I just wouldn't. I just wouldn't break that thought of being totally in control.

Another woman described how she expected her partner to read her mind:

It was very hard for me to discuss or tell anybody else what I was going through. I was putting a lot of expectations on my husband that he would understand what I was going through. I thought he should read my mind and just know by my quietness, and my body language, what I was feeling.

Even though the women suffered in silence they had an intense need to be seen and heard. One woman stated, “Maybe if I died or I killed myself, if I am dead, then at least maybe I will be seen.” Another described feeling that no one could hear her, “I felt that I was absolutely screaming and no one was saying it was okay.”

Having Nowhere to Turn

Despite valiant efforts to survive the onslaught of depression, feelings of isolation, hopelessness, and helplessness left the women feeling that they had nowhere to turn for help. The women’s perceptions of the ability of others to help were overwhelmingly negative. Although a few of the women spoke endearingly about their partners’ genuine attempts to help, most of the women described feelings of resentment towards their feeble efforts to make things better. Partners were most often described as being clueless, helpless, or frustrated. Although the women admitted that their partners knew something was wrong and wanted to help, they were woefully uninformed and completely unprepared to provide the help the women felt they needed.

The women frequently referred to their partners as “the poor man.” The inability of these women to define the problem and communicate their needs left their partners in an untenable position.

One woman sympathized with her husband’s no-win situation:

I think I drove him absolutely crazy, actually. Poor guy. I didn’t have a clue what I needed. I didn’t know what I needed myself. I was trying to fill my life with everything and so the last thing I would be able to tell him was what I needed. He worked long hours too and he would come home exhausted - and everything would be nice and clean - and
his plates would be off the table before he even finished them – "the model of efficiency." And I would just never sit down. He would say, "Why don’t you come and sit down and relax, and we can watch TV?" I just wouldn’t sit down. He really wanted to help and he had absolutely no idea how, absolutely no idea. And of course me not being able to tell him didn’t help.

Men’s efforts to help consisted of doing household chores, caring for other children, and encouraging their partners to rest. Unfortunately, the women perceived these efforts to be ineffective and often stress provoking. As the men became more frustrated with their unsuccessful efforts to help they began to back off and leave the women to solve the problem on their own. One woman described her husband’s predicament in the following way:

You know I think my husband felt very helpless. He wanted to help but he didn’t know how to help. And if he did do the dishes he did it wrong so then he would have my wrath upon him. So he just finally said, “I don’t know what to do.”

Throughout Phase I of the help seeking process, the women were consistently told how to feel better. One woman said, “I had these people that worried about me but they didn’t know how to help, so they would just give me pat answers and stuff like, “Buck up! You have a baby to look after.” Other women recalled being given explanations and advice such as, “It is just the baby blues,” “a nice bath will help,” “you need to get out,” “you’ll just grow out of it,” or “you need to get away from the baby for a while.” To a large extent, the women resented these simple answers for their serious problem. Although the women did not know what was wrong, they certainly knew that having a nice bath would not change their distorted thinking patterns or high anxiety. The women were particularly angry when their doctors behaved in a condescending manner or gave unhelpful advice as illustrated by one woman’s story about a visit to her physician:

So I went in there and she looked at me and said, “So what is wrong with you?” And I said to her, “I don’t feel right.” I couldn’t even express it. It was like I couldn’t even describe it. I didn’t know what postpartum was. I didn’t have a clue what it meant to be depressed. There was no literature. I knew what baby blues was but I had no absolute clue what postpartum depression was. My doctor told me there was nothing wrong with me that um, “I can give you some medication if you are feeling anxious.” I said no, of
course not I am still breastfeeding and she said, "Go buy a new pair of pants and go home."

Although providing help with household chores and childcare is commonly seen as beneficial for new mothers suffering from depression, the women in this study frequently perceived this form of help to be intrusive and judgmental. The women interpreted these gestures as further evidence of their incompetence and failure as a mother, as portrayed by one woman:

When people offered to help I felt guilty because I should have been able to do it myself, and people shouldn’t have to help me. So it was good and bad for me. And I just eventually got to the point where I just clammed right up and didn’t say anything to anybody. But I think if I had been able to handle the guilt thing it would have been good because there was help there, but I just wasn’t ready to accept it. I felt too guilty for needing it.

Many of the women recalled feeling offended by some of the practical help provided by others, but they were also willing to admit that this reluctance to accept help was, in all likelihood, related to their own internal struggle to come to grips with their depression. On reflection, the women began to wonder if seeking and receiving help constituted two different phenomena. Seeking help required women to communicate their needs, an action prevented by the requirement to keep the secret. Receiving help, particularly help of a practical nature, threatened women’s self-esteem making it extremely difficult to accept support that was genuinely offered. This conundrum for both the woman, and those around her, is illustrated in the following quote:

When I think about all the signals that I was putting out there ... I think it was like a catch-22. I was putting out that I am absolutely out of control, I am out of control but God help you, if you help me!

In an effort to protect their self-esteem and fragile emotional state, women found that help that avoided what one woman called, "stepping on toes in helping" was the most beneficial. This form of help is lovingly expressed in the following passage:

I have a mother-in-law who is an angel ... who was a lifesaver for me. She did what your mother did. She didn’t come in and clean up or anything. She just sat. I didn’t even want anybody to hold my baby and for her to be a first-time grandma and just sit there and not hold that baby - like wow, you know, that must be so hard to do. But she did, and I agree,
that kind of support is probably the best help you can get - definitely.

**Reaching the End of the Line ... a Turning Point**

Reaching the end of the line represents a significant turning point in the help-seeking process. Women described this point as “peaking,” “bottoming out,” “the worst of it,” “at my lowest point,” “going over the edge,” or “being a basket case.” The increasing symptoms and accompanying loss of control created a condition in which the women’s situations became intolerable. The majority of women experienced a peak incident that marked a time at which women could no longer keep the secret. These peak experiences included such things as yelling at or almost striking an older child, being unable to stop crying, fighting with their partner, experiencing terrifying panic attacks and making deliberate plans to commit suicide or run away from the family. Three of the women in this study had partners who experienced depressive episodes after the birth of their child and one woman stated that the onset of her husband’s deep depression provided the impetus for her to seek help. Another woman’s deep longing for death marked the end of the line for her, a time at which she could no longer wait to be rescued:

So finally we went to the cemetery one day. My husband’s father died when he was a young boy and he had only been to the cemetery twice, once to take me there, and now he wanted to introduce his son. So we went to the cemetery. I wanted to be dead. Like I envied people in the ground. And when we left there I was crying and I said to my husband and to my mother-in-law who is eighty-seven years old and doesn’t really understand this, I said “I need help and I don’t care what you say any more there is something very, very wrong and I am getting help.” There are worse things than death, like death actually seemed glory to me at that time because nothing else mattered.

The intensity of the symptoms and the loss of control experienced by women who reached the end of the line prepared them for that point in time in which they were able to identify the source of their distress and call it (PPD) by name.

**Calling it by name.** This critical turning point in the help seeking process provided women with new insight into the nature of their problem and prepared them to reach out for help. The women described this moment in time when they finally understood the nature of their
problem as "the light went on." The clarity that came from this acknowledgement enabled the women to begin their search for help. One woman described a moment of enlightenment when she recognized her symptoms to be that of PPD in the following way, "When my son was 6 months old I woke up and said, 'I have postpartum depression!' Literally, I was standing at the counter and I can see myself, I can visualize myself, 'Oh my God, I have postpartum depression!" Another woman described a similar experience as she recognized herself in the story of another, "I was reading the article and they had a name 'postpartum depression' and I read the magazine, the article, it's like, that’s what I have!" Although 10 women in this study came to this realization alone, the other 20 were "called on it" by a doctor, nurse, or close friend.

Knowing what it is. Calling it by name proved to be a moment that led to a sense of enlightenment or knowing. Knowing what it was prepared the women for a new phase in the help seeking process in which they could ask for help specific to their depression. Although the women expressed feelings of shame, embarrassment, and defeat when faced with the reality that mental illness had touched their lives, they also expressed a profound sense of relief that they could now make some sense of their situation. The women expressed relief in statements such as: "I am not crazy," "I am not losing my mind," "I can see the light at the end of the tunnel," and "I have something to hang on to." As the women called their depression by name they experienced a new readiness to seek help. In the following passage, one woman described the new sense of freedom that she felt when she finally knew what was wrong:

Freeing, When I was sitting there at the counter bawling my eyes out and thinking....this is it! And you know, I could give a name to my problem - or my incompetence - or my lack of coping - or my, my, my breakdown - and after that it really opened up whole new doors for me because I would start telling close friends that I recently discovered that I had postpartum depression.

Phase II: Giving In and Opening Up

Giving in and opening up describes Phase II of the help seeking process and refers to the
women's new willingness to seek and receive help. One woman stated, “I need to start saying, it is okay to ask for help. It is okay to accept help.” During this phase the women recognized the seriousness of their distress and realized that they could no longer struggle alone. Telling others about depression was not a simple task, however, and many women described being ashamed that they might have a mental illness or be considered crazy by others. **Putting self at risk** describes an assessment of the trustworthiness and abilities of others to respond to the women’s cries for help. **Knocking on doors** refers to the activity of revealing their depression to others and asking for help specific to the depressive experience. **Trying out options** refers to particular behaviour in which the women accepted, evaluated, and modified interventions and suggestions provided by others. Putting self at risk, knocking on doors, and trying out options culminated in a cyclical process that was influenced by the women’s expectations of family members, friends, and healthcare providers. The variability of these experiences was influenced by personal beliefs, previous life experiences, and experiences of care.

**Putting Self at Risk**

In the context of motherhood, asking for help for mental illness seems especially demeaning and frightening. For the women in this study the fear of discovery was real and terrifying. The participants shared fears of being judged, being “ratted on,” and being seen as an unfit mother. One woman stated, “You know you are at the end of the line, and you are trusting someone, and yet, you are in a system that feels...they almost label you an enemy.” Facing these fears required the women to put themselves at risk. Before the women could speak about the unspeakable, however, they needed to assess who could be trusted. The women expressed concerns such as, “when you’re thinking that you are going nuts the last thing you want to do is talk to strangers,” and, therefore, many women began to search for help from individuals in whom they had already established trusting relationships. As described by one woman, family
members and friends were often seen as the safest in taking this first step:

I didn’t tell anybody about it because of – how you were saying - that you worried about people taking the kids away and welfare and all that sort of stuff. So the only person that I told was my mom.

Another stated:

At three months my mother-in-law came to help and that was great but by that time I was already a basket case. And that was very helpful because she provided what I couldn’t. I think she was the first person I trusted to take care of my daughter and she provided what I couldn’t provide for my daughter, all the closeness, happiness, and laughter. But you know I felt so guilty that I couldn’t take care of my daughter. I was happy that she was there but I felt guilty that I couldn’t do that.

Although family members were frequently seen as less threatening than healthcare providers sharing concerns with one’s partner was not always possible. As in Phase I, the women continued to believe that their partners just didn’t “get it.” Although some men experienced a moment of enlightenment when they recognized the cause of their partner’s distress, the overwhelming majority remained bewildered. To avoid criticism the women kept secrets from their partners related to symptoms they were experiencing or treatments they were offered. For instance, several of the participants hid prescribed antidepressant medications from their partners. One woman’s vivid portrayal brings this experience to light: “I went home and hid them (the medications) in my room, in my closet under a pile of clothes, so my husband wouldn’t find them. I was so ashamed!” The women in this study perceived telling people outside of the family about their depressive symptoms to be extremely risky. In fact, three women never did confide in their family doctors. As one woman put it: “My doctor was trying very hard to get me to admit I had a problem. When I went for the check ups afterwards he kept asking, ‘Are you okay?’ ‘I’m fine’. I would be so stoic, ‘I’m fine.’”

Knocking on Doors

Knocking on doors describes a process by which the women sought help from a variety of sources including family members, friends, physicians, psychiatrists, PHNs, counsellors,
support groups, and church communities. Knocking on doors was not a one-time event. A majority of the women sought help from several different sources with varying degrees of success. Some women felt that help was readily available once they were willing to ask for it. These women spoke about a wonderful doctor, a PHN that “gave of herself,” and a church community that helped to pay for counselling. Sadly, however, several women shared stories of “being shuffled from one nurse to another,” “going to five different doctors,” and “just swimming around looking for help, not knowing where to go.”

**Expectations of family and friends.** The women’s expectations of their family and friends influenced their choice of whom to approach for help. During the second phase of the help seeking process the women continued to believe that male partners lacked the knowledge and understanding to provide the help so desperately needed. Most of the women in this study viewed PPD as distinctly different than depression experienced by men. This belief led the women to assume that men could never fully understand their suffering. This belief may have contributed to the perception that husbands were “clueless” and therefore, not the appropriate person to ask for help.

A significant number of women in this study believed that female friends, particularly those who had experienced PPD, were important sources of support. Not all female friends and relatives were seen as helpful, however. For instance, many women spoke about avoiding the company of other women who appeared to be “perfect mothers.” One woman illustrated this belief as she described her reluctance to confide in her sister:

> My sister and I actually had our babies within ten days of each other and I thought she would be a real support, but she just had no depression at all and was up baking bundt cakes for the neighbourhood on day three. You know, so I had no rapport with her.

The women described seeking out friends who were “willing to talk about it” and avoiding friends who backed away and looked uncomfortable with the discussion.
Expectations of healthcare providers. As the women reached out for help they made careful assessments of the characteristics of healthcare providers, expecting them to be friendly, supportive, reassuring, patient, understanding, knowledgeable about the issue of PPD, and attentive to their unique needs and concerns. The women also expected healthcare providers to be willing to do the following: ask questions related to symptoms that might signal the presence of depression, recommend different options of care, refer to other services as needed, and provide ongoing monitoring of their mental health. The women wanted this care to be provided within a trusting relationship that valued individual rights and privacy. Unfortunately, the women continued to experience feelings of inadequacy, perceiving that others did not believe them or were judging, criticizing, or testing them. The feeling of being criticized was particularly evident in the manner of some healthcare providers who provided care and advice, particularly about breastfeeding. The women described some nurses who acted like “mother superior” or condemned the woman for being a “horrible mother” when they had problems with breastfeeding.

A common theme throughout the data was the women’s need to feel “comfortable” and “connected” with their healthcare providers. This connected and comfortable relationship with one woman’s PHN is described in the following statement: “She actually understood my frustration because she went through a similar situation. And I felt comfortable around her. She visited my house actually too, and we just connected.” The women described healthcare providers who were able to connect as sincere, compassionate, nonjudgemental, being like a neighbour, willing to listen and give of their time, and taking it upon themselves to check on them. Frequently, the women described being surprised that the PHN would continue to call or visit on a regular basis. One woman described her public health nurse in the following way: “Well she was friendly and soft spoken and I remember her sitting in the kitchen just relaxed and
I didn’t feel like she was being rushed or being clinical at all. She came for a visit - like the neighbour.” Another woman described being able to have a “really open, ongoing conversation” with her doctor.

The women expected healthcare providers to ask questions that related to the recognition and detection of PPD. A few women described visits to a doctor who asked them questions, recognized the symptoms of depression, and suggested treatments that might be helpful. Unfortunately, many women believed that their doctors were unable, or unwilling, to ask the right questions. One woman tearfully described her visit with her doctor: “Why didn’t my doctor say something? She was my doctor. She’s my doctor. Why didn’t she just say, ‘Well come in, we’ll sit down.’ Just do an assessment on me. Ask the questions that you are supposed to ask.” Another woman described how her doctor patiently waited for her to initiate the conversation, “I went to see my doctor and he said, ‘Well it is about time you came in. I really thought there was something happening for you there’… because he recognized I was having these problems but he didn’t say anything.”

The women continued to feel vulnerable and feelings of hopelessness and helplessness were common. At this point, the women expected healthcare providers to give hope and reassurance that good treatment was available and that their depressive symptoms would subside in time. One woman recalled her doctor’s reassuring words: “But at the same time he reassured me that, that was okay. That there was nothing wrong with me on antidepressants, that it didn’t make me bad or anything.” Another recalled how her doctor said exactly what she needed to hear, “It could be a chemical imbalance you are going through. It is not a weakness.”

**Trying Out Options**

During Phase II the women engaged in a process of trying out options in which they accepted, evaluated, and modified treatments and strategies suggested by family members,
friends, and healthcare providers. Options included talking to friends, taking medications, seeking counselling and support, using public health nursing services, and going it alone. The overall goal of this activity was to reduce the women’s depressive symptoms and to increase their sense of control.

**Talking to friends.** Twenty-five of the 30 study participants talked to friends about their depression at some point during their depressive experience. For 19 of these women, talking to friends played a key role in their journey towards recovery. Friends considered to be helpful were seen as trustworthy, dependable, somebody one could confide in, and someone with whom one could feel comfortable. One woman described the role talking to other mothers played in her recovery:

> That is how your mind heals – you have to talk about it. I knew that was how I was getting better but I only talked to who I was able, who I was comfortable talking to. I talked a lot and over the years I have talked less and less as I have gotten better.

Although the women valued the companionship of other women with children, many described having difficulties finding opportunities to share their experiences with other mothers as described by one woman in the following passage:

> I felt that I was seeking places to share, I was, you know, going to the park or anyone, in the hope that a mom would sit down beside or something, so we could just talk. Is anybody out there experiencing this? I tried to seek out areas where I might encounter young moms and be able to talk. Yeah, it was kind of a lonely feeling.

**Seeking medical help.** In general, doctors were viewed as the primary source of help for women with PPD. With consistent regularity, family members, friends, PHNs, and others referred the women to their family doctors. Some women described experiences of receiving excellent medical care from a doctor who took a holistic approach and recommended such strategies as couple therapy at an island retreat, encouraging partners to participate in office visits and decisions, providing videos and reading material, ensuring ongoing and consistent follow-up, and referring them to other appropriate community services while taking into account
their ability to pay. Other women shared stories about needing to switch doctors, or to give up on doctors who “couldn’t figure it out,” suggesting that the medical community needed “to wake up and get the picture.”

Of the 25 women in this study who sought help from family physicians, 24 were prescribed antidepressant medications. Of these women, 19 found the medications to be helpful in relieving their symptoms, three refused to take medications because they were afraid of possible negative effects on the baby through breastfeeding, and two stopped taking them because of intolerable side effects. Of the six women who did not take medications, three were never identified as being depressed by their doctor despite regular office visits for vague complaints during the postpartum period, one never did reveal her depression to her doctor, one was referred for counselling instead, and one believed that using medications was a “cop out” that did not address the real issue.

Going on medications was not a decision that the women took lightly and although some women stated that they could not “get on medication fast enough,” most expressed profound reluctance to make this difficult decision. For these women, taking medications was accompanied by profound feelings of guilt and inadequacy, as related by one woman in the passage below:

I think I didn’t want to go on medication. I thought that I was a bad person if I go on medication - that I don’t have enough coping skills - that I couldn’t handle the situation myself - that I was a total failure if I go on medications.

The beliefs and opinions of partners and family members played a pivotal role in the women’s decision about whether to take medications. As illustrated in the statement below, many women related incidences in which their partners expressed strong objections to the use of antidepressants:

No! You don’t need medication. You can fight this thing. You can fight it. You just have to get into the routine. What’s so difficult about it? Everybody else is doing it, you know.
Young kids are having babies that shouldn’t. Why can’t you?

Although some women believed that they were able to choose whether they took medications or not, the overwhelming majority was faced with a situation in which they felt that they had no choice. By the time the women reached the end of the line, many were experiencing significant distress, including terrifying panic attacks and delusions. Waiting to be rescued was no longer possible. One woman described the sense of urgency she experienced, “I pleaded with her (the doctor) and I said, ‘I am not sleeping and you have to give me something because I am a wreck. I can’t – I will not survive.’” Women who decided to take antidepressants began a process of managing their medications. Throughout this process the women waited for the medicine to take effect, monitored side effects, adjusted dosages and, on occasion, decided to discontinue taking the drugs. For some participants, medications proved to be the magic bullet that helped to “keep them level.” One woman shared how this difficult decision proved to be the right one for her:

I didn’t want to take medication at all. I just didn’t want to do it. And then, I am the complete, ultimate failure of a mother. But I decided to do it because I didn’t want to go on like this. And that was the best decision that I made.

For other women, side effects were a significant problem. The participants spoke about problems with weight gain, hair loss, constant thirst, fatigue, and decreased sexual libido. Women described being in a haze, feeling monotonic, being “screwed up in the head,” feeling like being “acid,” feeling like a zombie, and feeling stoned. As symptoms abated and the women adjusted to the side effects they began to worry that they would be “taking medications forever.” One woman described her fear in the following words, “I am terrified to come off the medication. I think I can’t go back there. If I ever go back there I don’t know, I know I won’t make it. There is no turning back. That hole is so dark and scary.” Reasons for stopping medications during Phase II included, not being able to handle the side effects, breastfeeding or getting pregnant, and
gradually feeling better. Pregnancy and lactation were not always seen as reasons to stop taking medications by healthcare providers and several women deemed to be at high risk for another episode of depression were encouraged to continue taking their antidepressant medications. These women were assured of the safety of medications during pregnancy and lactation, and were monitored closely by the reproductive care team.

Seeking counselling and support groups. Fourteen participants in this study received psychological or psychiatric counselling, and 11 of these women found the sessions to be helpful. Eleven of the 14 women were taking medications concurrently with counselling. The act of seeking help from a counsellor was fraught with anxiety and the women worried that they would be stigmatized as mentally ill or unable to care for their children. The women were also afraid that visits to a counsellor or psychiatrist would be recorded on their medical record, posing a threat to future employment opportunities. Counselling was viewed as a long, slow process that one woman described as “talking for weeks on end.” Psychiatrists, psychologists, and counsellors who were viewed as knowledgeable, willing to listen, willing to give of their time, willing to include partners in the process, and willing to work hand-in-hand with the general practitioner were considered to be the most beneficial. The women who were disappointed with their counselling interventions described counsellors as impersonal, not up-to-date in their knowledge of PPD, distant, and overly clinical. Ineffective services were described as expensive and inaccessible. Although psychological counselling was deemed to be an appropriate, and sometimes, essential treatment by the women in this study, the lack of affordable community services constituted a significant barrier for many. Although these women had medical coverage for psychiatric services and mental health counsellors, private psychological counselling was costly. Some women talked about paying $75.00 an hour for counselling and described having to borrow money from family and friends to pay for services. Those who could not afford private
counselling sought help from counselling services at local churches for a minimal charge.

Another decided not to go to counselling because of a previous negative experience during her adolescence:

I didn’t go through counselling because I used to go through counselling a lot when I was younger, when I was a teenager, and they always told. They would tell my parents. They would tell other people that they worked with.

Nine women in this study sought help from a support group or mother-baby group. Three of the women attended “mom and tot” groups at the health unit while six women attended therapeutic groups focused on peer support for depression. Five of the women who attended support groups believed that the sharing of experiences was instrumental in providing them with insight into their situation. Four women did not find the groups to be beneficial. For instance, one woman who attempted to find companionship in a mom and tot group in which the other participants had not experienced depression, described “feeling like an outsider,” accentuating an already existing belief that nobody understood. Other women expressed disappointment that they did not build relationships with others in the group or that facilitators lacked the necessary skills to provide a therapeutic group experience. Reasons given by the women who did not attend support groups included not being aware of a local resource, not being able to find a group specific to PPD in their area, not wanting to be around other people who were also depressed, or not wanting to open up to strangers. Although almost all the women believed that sharing their experience of PPD with others who had suffered similarly would be helpful, finding the resources and opportunities for such peer support proved to be a complicated and often discouraging process.

Using public health nursing services. Sixteen women in this study used a variety of public health nursing services including, home visits, drop in clinics, breastfeeding support, and mom and tot groups. These women frequently called or visited the health nurse for advice and
support related to breastfeeding, childcare, immunizations, or parenting issues and several women described going back to the health nurse repeatedly “just to talk.” One particularly resourceful PHN had a significant effect on two women in one of the groups. This PHN encouraged one woman who was beginning to feel better to attend a peer-support training seminar and then subsequently linked the other woman to this newly trained peer counsellor. Both women described this peer support relationship to be a key factor in helping them towards recovery. In the following example, another woman described the creative efforts of her particular health nurse:

I had a really good health nurse too with my first one. Not with the second one - we would just bundle up the little guy and take him and she would go on walks with me because she said, “You need to get out. Let’s go for a walk around the block.”

The women expected PHNs to believe them, to be sensitive, to be creative in their approaches, and to be respectful to individual situations. The perception that PHNs could be a friend facilitated the development of trusting relationships in which many women developed close and long lasting relationships with the PHN in their community. The women who felt judged or criticized by PHNs, particularly in relation to breastfeeding, did not continue with these relationships.

Going it alone. Going it alone was also an option chosen by some women. In this study, four women never sought professional help specific to depressive symptoms during the postpartum period. One of these women related her belief that her depression was now chronic, two others described being recovered, and one woman was considering seeking help. One woman in this study decided to go it alone after her sustained and persistent efforts to find help, proved unsuccessful. This particular woman described an incident in which she felt frustrated, angry, and abandoned by the system:

I talked to a lady and she asked me exactly how old I was, how many kids I had and nobody ever got back to me. She said it would be within the week. It’s been seven
months. I could have called back too, right, but I thought you know, I tried. I did what I could at the time. I wasn’t ready to just keep trying and trying and trying. I thought okay, they are not going to help me, and so it’s me again! I just decided on my own to get better and just to take control and stop being so, I don’t know what the word is, like you were saying about being strong and stuff.

The Influence of Perceptions and Beliefs on Help Seeking

The women’s strong personal beliefs about both the nature and cause of PPD influenced their treatment choices. Some women believed that PPD was caused by hormonal or chemical shifts after the birth of their baby, and that antidepressant medication, prescribed by the family doctor, could address this chemical imbalance. Other women believed that depression had a strong psychological component, possibly related to problems in childhood. These women felt that although medications might be helpful, they were “not the be all and end all to solving the problem,” and psychiatric or psychological counselling, or just talking about it, was an important component of every treatment plan. Some women believed in a spiritual component to the cause of depression expressing feelings of being “possessed” or “attacked by evil.” These women believed that their first avenue of support was provided through their church communities in the form of prayer, social support, and practical help such as providing meals and financial assistance. Finding a balance between the need for prayer and the need for modern medicine provided a particular challenge for women of faith.

Many participants believed that PPD was completely different from depression in general. PPD was seen as a condition that only affected women and therefore, men could not possibly understand the seriousness of the situation. This belief led to a series of actions that may have complicated the help seeking process. For instance, several women made unsuccessful attempts to find a female doctor, believing that a male doctor could not understand a woman’s experience. As one woman stated, “There’s no way they can ever experience anything on that level, so how can you expect them to understand it? They can read all they want in medical
books but until you’ve gone through it, you don’t understand.” This belief may account for the fact that only one woman in this study attended a group-counselling session in which both men and women were seeking help for depression.

**Feeling Better: An Uneasy Peace**

As the women sought and received help for their depressive symptoms they began to feel better. Feeling better was described as: starting to feel normal, adjusting to things, having better coping skills, and being able to ask for help. The women worked hard to balance feeling better with the ever-present fear of relapse. One woman described this uneasy peace in the following way: “I don’t know that I really think that I’ll ever be totally better. I think it will always be there for me.” Another described the daily struggle towards recovery:

> It is just like little baby steps you know. It is like – okay, I went through postpartum depression - and then there are days where I won’t admit it to anybody. Nobody is going to find out that I went through that. And then the next day it’s, “No, it’s okay that I had that.” So it’s still an ongoing thing.

Throughout Phase II, the experience of PPD remained a distinct entity to be dissected and analyzed, not yet fully integrated into the women’s hearts, minds, and lives. As one participant tearfully and eloquently stated, “It (depression) is just here. It is beside me. It isn’t a part of me yet. And I don’t know how that process will be.”

**Phase III: Tuning-in to Self**

*Tuning-in to self* constitutes Phase III of the help seeking process. During this final phase the women looked back on their experience, grieved losses suffered, and forgave themselves and others. The women also engaged in the process of moving forward described as “getting past it,” “accepting it,” “making it part of me,” “being okay with it,” and “coming to terms with it.” Moving forward consisted of weaning off medications, making decisions about future pregnancies, and renewing relationships with family and friends. As the women integrated the experience of depression into their lives they looked inwards for strength and found a renewed
confidence in their motherhood abilities. Talking about their experiences and reaching out to help others assisted in the healing process.

**Looking Back**

As the symptoms abated the women tried to make sense of their experience through a process of *looking back*. The struggle to survive, or as one woman called it, “the battle for myself,” took a terrible toll on these women and their families and many described feeling ashamed and embarrassed about how they had behaved during their depression. All of the participants in this study grieved for the losses suffered. Some believed that they needed to apologize for behaviour that had been hurtful to others. For instance, during one of the focus group sessions a young mother shared a tearful apology she made to her daughter, “Mummy always loved you, but I went through a hard time. It wasn’t your fault and I just want to say I am sorry.” Another participant described telephoning her ex-husband to apologize for behaviour she believed had contributed to the dissolution of their marriage. Some of the women believed that they might never be better and had resigned themselves to this eventuality. In this regard, one woman shared her belief that she might never get off her medications: “I have kind of resigned myself to the fact. I guess I’ll be taking medication forever, as much as I hate it. I have tried to go down but I cannot get off of it.” Another woman shared her belief that she would never be the same again: “I am permanently scarred. I know now that the chemical fluctuations that went wrong in me with the serotonin is permanent. It is pretty obvious now…. It doesn’t always go away.” Sadly, the following passage is only one of many that highlights one of the most tragic losses of all, lost memories of their children as infants:

Most things I don’t remember. I don’t remember when (my babies) learned to walk. I don’t remember a lot of things - I have to ask my husband. I don’t remember them being little tiny babies. That was totally robbed from me.

The experience of PPD left the women with a nagging worry that their depression may
have had a negative effect on their children, however, in almost every focus group these women encouraged each other not to be “wrapped up in guilt about it.” The women who were no longer feeling depressed described their older children as bright, happy, and well adjusted. As one woman put it “Maybe no harm was done.” Forgiveness was also a key theme in the interview data. The women not only worked hard at trying to forgive themselves, they also worked hard at forgiving others perceived to be unavailable, unconcerned, or hurtful. Some women remained angry at a system that did not provide accessible and adequate resources or supports.

Moving Forward

As the women gained new insight into their depressive experience they began to make conscious decisions to move into the future by weaning off treatments, planning for pregnancy, and renewing relationships with family and friends. Moving forward required that these women look inwards for strength formerly provided by others. This inner strength enabled them to monitor their recovery and protect themselves from relapse.

Weaning off medications. During this phase the women set themselves to the task of weaning off antidepressant medications. This process was extremely stress provoking and the fear and anxiety felt by many is reflected in the statement of one:

It’s scary to come off. I just didn’t want to go back. I didn’t you know. I thought, “okay, I’ll go down to ten milligrams and see how I am doing.” And now I am off and just, I am watching myself because I just don’t want to get back to where I was. And it’s scary because you think, “What am I doing?” I don’t want to be on medication for the rest of my life but I don’t want to suffer either.

Others were beginning to feel a new confidence that they would be able to get off the medications when the time was right. One woman described this new faith in her ability to recover: “Well, I’m on medication again but I know I’m going to be able to get off of it and, you know, get on with my life and I’ll be the same person I was before.”
Making decisions regarding future pregnancies. Depression in the postpartum period occurs during women's childbearing years and consequently all of the women in this study were challenged to made careful decisions regarding future pregnancies. The fear of having another episode of PPD led these women to weigh the risks of becoming pregnant again. One woman shared her fears in the following statement:

So I have that fear. You know, if I have another child, will I be depressed again? And will I know it? And will I... you know... all these things...like I just get this fear that it takes over me and I can't think logically and that scares me, you know. Because I'd like another one - I want a little girl but if that's the price ...

Although most of the women in this study worried about having another baby, only two decided not to have more children because of having a recurrence of the depression. One woman shared this difficult decision: “It frankly scared me enough that we didn't discuss having anymore. The thought was too frightening for me to perceive going through it again.” The women who did decide to have more children took practical steps to protect themselves from relapse such as visiting the reproductive psychiatrist during the pregnancy, deciding to go on medications during pregnancy or in the early postpartum period, or proactively setting up support persons to assist with housework and childcare. One woman described how she and her husband arranged for help as soon as they found out she was pregnant again:

My husband said right away “The first thing we are going to do is we are going to get you some help.” And actually I still do. I have somebody come to the house every day to help me, between four and seven; you know that really crunch time.

Renewing relationships. At this point in the help seeking process family relationships took on new meaning. Of particular importance to all of the women in this study was the renewal of loving relationships with their children. As described by the two women in the passages below a new ability to laugh and play with their children was a tangible sign of recovery:

I knew I was dealing with it better when I could enjoy her and I remember that, that time when it came, when I could really enjoy all the phases she was going through instead of thinking, “Oh, when she's going to do this then I'll be happier” I began to enjoy the phase
that she was at. At that time I knew I was better.

The time when I was at my worst was my son's first birthday. I couldn't even be happy at his first birthday and now I'm so glad that now I can be happy and smile and laugh and play with him, and play with her. It isn't a weight on me anymore, pulling me down into that dark hole anymore. So I can enjoy my children.

The women's partners also began to play a more important role in helping the women feel better. Many women now looked to their partners for emotional and practical help. Caring partners were seen as those who encouraged these activities by, as one woman called it, "giving me space, giving me leeway." One woman described how her husband monitored her moods and intervened on her behalf:

   My husband was really, really supportive, just right on top of it and still really is. If I am feeling blue he will look at me and say, "Are you down? Are you depressed today?" And he wants an answer from me. He doesn't want a wishy washy answer. And I will say, "Ya, a bit." "Okay, go to bed." Because he knows I love to go to bed. He knows I can never get enough sleep. And he says, "Okay, I'll take the kids. Go to bed." And I sometimes do listen to him, so I go to bed. I am really lucky.

Another woman described how her husband just sensed what she needed, a far cry from the "clueless" men described during Phase I:

   I think my husband has sort of pitched in too. For Valentine's Day he got me an afternoon at the day spa and things like that. So that just sort of reminds me that he's there and he knows what I'm going through and that it's hard. So he's willing to let me know it's okay to do things for myself and have time to myself too.

Finding strength within. During this final phase of the help seeking process the women began to look inwards for strength. Looking inwards required that these women undergo what one participant called, "a kind of self-assessment" consisting of self-reflection and self-talk that provided the insight, hope, and reassurance formerly provided by others. Many of the women described being better able to understand what they needed and better able to communicate those needs to others. Depression came to be viewed as way of letting one know it is time to look out for one's self and the women described such activities as finding time for solitude, doing things for oneself, playing with the children, letting housework wait, and engaging in physical activities
such as gardening or swimming. A new sense of self reliance and self confidence enabled these women to reconnect with friends, take renewed interest in former activities, and be more willing to accept help with childcare or housework. Throughout this phase the women monitored their recovery and protected themselves from relapse by maintaining a heightened awareness, a process described as “monitoring myself,” “catching myself,” “watching myself,” “being more aware of myself,” “listening to myself,” or “being on top of it.” One woman described how she monitored herself in the following way:

I haven’t had any depression for the last two years and that’s really good. I’m really proud of that. Yeah, you get little moments, well I don’t call it really depression, but it’s just you’re down, down, but it’s only because I’ve learned to catch it right away and not hide it any more. Okay, if you go downhill again, you’ve got to stop right there, you know, you just have to, that’s what I do usually. I sit down and think about it. “Okay, what did I do to put myself down again and how can I change it?” It sometimes just little things that just keep going and going and going and so you just stop right there.

Another woman described how this heightened awareness and new ability to monitor her mood provided her with tools she did not have early on in her depression: “I’ve caught myself too, kind of feeling on the decline, and you can catch yourself, but I look back on it and I’m thinking it was the same decline, I just didn’t catch myself.” The above activities were accompanied by particular protective strategies described by one woman as taking measures:

So I do take measures, like I sit down and have a cup of tea or I take time and play a game with the boys, or you now, not being so concerned about what I should be doing but just do what I’m doing and enjoy what I am doing.

Contact with healthcare providers. As the women learned to depend more on themselves and less on others they were less likely to seek help from healthcare providers. During this final phase, help seeking was limited to occasional visits to the doctor for advice on weaning from medications or casual calls or visits to the health nurse to be “checked up on.” The women described healthcare providers who “just watched me” or “called me off and on” as helpful.
A New Sense of Self

The journey out of depression moved the women towards healing and growth. As they integrated the experience, forgave themselves and others, and made practical plans to protect themselves from relapse, these women began to feel normal again. The women described this as “feeling like me again.” This normal self was accompanied by a new self, forever changed by the experience, but ultimately wiser and stronger. As one woman said “the experience through postpartum has really taught me a lot about myself and it has been a real learning experience for me.” Another spoke about using the experience for good:

I am allowing it to make me into a good person, a better person, I guess I could be bitter and resentful and just stay there but it is okay, and, I am becoming a better person because of it and along the way I am managing to help other people.

One woman stated that to “suffer silently is a killer” and in the following passage she described the sense of urgency she felt -- *to speak out and to reach out*:

We need help and we need to help each other. So for me, I want to help somebody now. I have this real desire to do that because it is not fun and people don’t understand. You need to talk to somebody that can understand.
CHAPTER V: DISCUSSION

The purpose of this grounded theory study was to explore and describe women's experiences of seeking and receiving help for PPD from family, friends, and healthcare providers. Help seeking emerged as a complex and evolving process. The nature of PPD gave "rhythm, pace, form and character" (Strauss & Corbin, 1998, p. 179) to this help seeking process. In this chapter the study findings are presented within the framework of the three-phased help seeking process that was identified. The discussion includes a comparison of the findings from this study with those of other related studies published in the literature.

Help Seeking for PPD: Overview of the Findings

Findings from this study indicate that help seeking for PPD is a complex process that occurs over time and is intricately connected to the course of the depressive experience. In this study, PPD is described as "falling apart" and the ensuing process of help seeking consists of three phases: (1) waiting to be rescued, (2) giving in and opening up, and (3) tuning-in to self. Whom women turn to for help, and what kind of help women find most beneficial, varies within the phases. For women who experience PPD, the help seeking process occurs during their emergence into motherhood, a transitional process described by Nicolson (1999) as a "status passage" (p. 175). Nicolson suggests that during the transition to motherhood a dramatic change occurs in which women experience a loss of their former self and establish a new self as mother.

Phase I: Waiting to Be Rescued

Falling Apart

The women who participated in this study described the experience of PPD as "falling apart," a time marked by distressing physical, emotional, and cognitive symptoms. The women described having problems with eating and sleeping, feeling that their body was shutting down, feeling overwhelmed, guilty, inadequate, and misunderstood, being afraid, having terrifying
panic attacks, contemplating suicide, experiencing horrifying thoughts and delusions, and being plagued by a terrifying sense of loss of self. The notion of falling apart is described in other research studies exploring the experience of depression in women as the downward spiral (Wood et al., 1999, p.213), going to the gates of hell and back (Beck, 1992, p.168), encountering terror (Beck, 1993b, p.44), living in terror and panic (Wilkinson & Pierce, 1997, p.105), and slipping into a deep, dark hole (Schreiber, 1996, p. 478). Although women in the current study described being unable to swallow, starving themselves, and being unable to sleep these findings were rarely mentioned in other research studies exploring the phenomenon of PPD. These symptoms may be related to overwhelming anxiety, or exist within the normal range of somatic symptoms experienced after delivery, however, loss of appetite and insomnia are key features of depression (American Psychiatric Association, 1994) and may be the only visible sign of the intensity of a woman’s internal struggle.

The participants in this study viewed depression as a malevolent force over which they had no control, a phenomenon supported in the literature related to the experience of depression for other populations. This is similar to findings in a study that explored the meaning of recovery from depression for women outside the postpartum period (Chernomas, 1997). Women described depression as an “it,” a force that invaded the body and took over. Similarly, in a study exploring the meaning of depression among depressed males, Heifner (1997) noted that his study participants perceived their depression to be an aggressive, overpowering force that beat or drove them down.

Many women in this study described their feelings of falling apart as being accompanied by panic attacks. Panic attacks are identified in the DSM-IV (American Psychiatric Association, 1994) as a discrete period of intense fear or discomfort, in which four (or more) of the following symptoms develop abruptly and reach a peak within 10 minutes: palpitations, pounding heart, or
accelerated heart rate; sweating; trembling or shaking; sensations of shortness of breath or smothering; a feeling of choking; chest pain or discomfort; nausea or abdominal distress; feeling dizzy, unsteady, light headed, or faint; feelings of unreality or being detached from one’s self, fear of losing control or going crazy; fear of dying; numbness or tingling sensations; and chills or hot flashes. In addition, frequent and unpredictable panic attacks can produce a fear of being alone or being in public places and are often followed by a fear of having another attack (World Health Organization, 1996).

The prevalence of both PPD and panic attacks has not been well studied, however, severe anxiety and obsessionality are known to be prominent features of PPD (Nonacs & Cohen, 2000). Qualitative studies are exploring the meaning of the experience of panic after childbirth and the significant negative effects this disorder has on women’s mental health and on family functioning. For instance, in a phenomenological study conducted by Beck (1998b) six women who experienced panic after the birth of their infants described significant impairment in their quality of life as they struggled to care for their children. These women described extreme feelings of guilt and disappointment, poor self-esteem, exhaustion, and fear of residual effects on their children. All of the women in Beck’s study sought psychiatric help and five took medications to treat their panic. Although there is debate in the psychiatric research literature about whether panic and depression represent a single disorder or a separate comorbid disorder, Kessler et al. (1998) suggest that panic may represent a severity marker of depression rather than a comorbid condition. If this is so, early intervention for women who experience panic is critical.

Findings from the current study on help seeking for PPD suggest that the most defining characteristic of women’s experiences of falling apart is their overwhelming feeling that they have lost themselves. Loss of self is a well-developed concept in the psychological literature (Brown, 1998; Ross, 1992) and is frequently discussed in the literature related to PPD (Beck,
1992, 1993b) and depression in other populations (Chernomas, 1997; Czuchta & Johnson, 1998; Jack, 1991; Schreiber, 1996). Female participants in Schreiber’s study described feeling incomplete, unintegrated, or missing valuable pieces of themselves. The process of recovery for these women involved an attempt to answer the question “Who am I?” Other studies have described the notion of “loss of self” as dying of self (Beck, 1993b, p.44), identity confusion (Wilkinson & Pierce, 1997, p. 105) and the stranger within (Badger, 1996, p. 151).

Jack (1991) suggests that the term loss of self as used by depressed women is verbal shorthand used to convey a number of things to the listener. What does the term loss of self tell us about a woman’s inner world? How does one describe this lost or divided self to others? For the women in the current study words and phrases such as, “I wasn’t myself” or “I couldn’t reach myself,” remained inadequate as a means of conveying the true meaning of their inner experience to others. The women’s perception that they had lost themselves may refer to loss of voice within relationship, loss of self-esteem derived from trying to fit an image provided by someone else, loss of authenticity, or loss of intimacy. Ensuing feelings of hopelessness and helplessness may stem from the sense that moving towards one major goal (e.g. motherhood) forecloses others? Could it be then, that the birth of a baby places untenable demands on a women’s self-esteem, her sense of intimacy with others, and her sense of authenticity in relationship with her baby, her partner, and significant others in her life?

Findings from this study indicate that women believe that PPD is distinctly different from depression experienced by women outside of the childbearing period. The assumption that PPD is an entity distinct from non-PPD is also implicit in the research literature on PPD. Surprisingly, most research focused on non-PPD entirely overlooks the influence of childbirth in the aetiology of depression. Although findings from the qualitative studies reviewed suggest that depression follows a trigger event such as multiple losses (Unsworth, 1999) and childhood trauma or abuse
(Schreiber, 1996), no study was found that discussed the role pregnancy, childbirth, or
parenting a new baby might play as a trigger for depression. Schreiber (1996) states that
"depression is the most studied mental illness phenomenon" (p. 469) and therefore, the wealth of
knowledge currently available about this phenomenon may represent a valuable resource to
expand and inform our understanding about the experience of PPD. Women who experience
PPD may benefit from safe and effective care provided by individuals and healthcare providers
who have particular knowledge about depression in other populations.

**Trying to Survive**

In the initial phase of the help seeking process women attempted to "do something" about
their depressive symptoms. Keeping the secret, not wanting to think about it, trying to analyze it,
and giving off signals were covert strategies used by the women to protect themselves from the
criticism and judgement of others. When faced with social situations women silenced themselves
by "putting on a face," an activity one woman described as "feeling like a big sham." Women's
active and self-imposed withdrawal from social contacts has been described in the literature as
"an active silencing of self within their relationships" (Mauthner, 1999, p. 156). Women in
Schreiber's (1996) study used this silencing activity as a means to move away from the intense
fear they were experiencing. Much like women in the current study, participants in Schreiber's
study became involved in activities such as going back to school or work to "fix the problem" (p.
479). This activity has also been described in studies exploring the experience of depression for
men (Heifner, 1997). For instance, men in Heifner's study described being engaged in elaborate
secret keeping, living a lie, and guarding their real selves (p.14). The need to hide depressive
thoughts and feelings, the sense that the authentic self is missing, and the subsequent withdrawal
from social contacts leave individuals unable to ask for help, a situation described in the current
study as waiting to be rescued.
Having Nowhere to Turn

Findings from this study indicate that there are multiple influences on the help seeking behaviour of women with PPD. Personal perceptions, beliefs, intensity of symptoms, cultural norms, and the accessibility and availability of services and supports influenced these women’s help seeking behaviour. This finding is supported in the literature related to help seeking for emotional distress for other populations (Gourash, 1978; Rickwood & Braithwaite, 1994).

During the early phase of the depressive experience the women in this study perceived that they had nowhere to turn for help. These women believed that family members lacked understanding and the wherewithal to help and that healthcare providers lacked adequate knowledge about the issue of PPD and were indifferent to their suffering. These negative perceptions of others ability to help placed family members and healthcare providers in a difficult position. The women frequently interpreted advice and suggestions from others as patronizing and offensive, further increasing their sense of isolation.

These findings are supported by Beck’s (1993b) qualitative study in which women described feeling alone and isolated because no one understood what they were experiencing. Women’s inability to describe or explain the feelings and their belief that no one could help further complicated their situation by leaving partners, family members, and healthcare providers in the dark as to how to help. Mauthner (1999) found that women in her qualitative study had great difficulty talking about feelings to others suggesting that women’s silence was often sustained and reinforced by a reluctance among some male partners, relatives, friends and health providers to acknowledge, accept, and respond to the women’s emotional and practical needs.

Reaching the End of the Line... a Turning Point

Making the decision to ask for help was preceded by a crisis event in which circumstances related to falling apart were no longer tolerable, a time described in this study as
reaching the end of the line. Reaching the end of the line was marked by such events as yelling at or almost striking the infant or another child, experiencing terrifying panic attacks, experiencing obsessive thoughts of death, or contemplating suicide. This crisis represented the point at which women moved beyond their internal struggle and reached out for help. This crisis event has been described in the research literature on depression as seeing the abyss (Schreiber, 1996, p. 477), a turning point (Steen, 1996, p. 82), and reaching a crisis (Badger, 1996, p. 153). Peden further indicates that reaching a crisis such as admission to a hospital, or suicidal ideation provided the impetus for women in her study to make a conscious decision to seek help. This finding is also supported by a Canadian study that examined the role of depressive symptoms and comorbid psychiatric diagnoses in medical treatment seeking (Galbaud du Fort, Newman, Boothroyd, & Bland, 1999). In this study psychomotor retardation, suicidal ideation, comorbid mania, and comorbid panic attack predicted treatment seeking. Reaching a crisis leads to the recognition of the seriousness of the problem and a conscious decision to take action.

Phase II: Giving In and Opening Up

Putting Self at Risk

Asking for help specific to PPD was identified in this study as giving in and opening up, a process described by Schreiber (1996, p. 479) as “telling my story.” Asking for help for PPD was not risk free. Protecting one’s self and the baby required women to engage in a careful assessment of who to tell and how much to tell. This finding is supported by research that explored the experience of depression in women outside of the postpartum period. For instance, Schreiber describes a process termed “controlling the information” (p. 479) in which women decide how much honest information to reveal to others without causing repercussions. The women in Schreiber’s study described feeling unsafe about sharing information with people they perceived to be judgemental or critical. Chernomas (1997) found that women in her study
carefully considered the response of others when making decisions about who to tell, how much to conceal, and how much to reveal. These participants described being cognizant of the serious implications that could result from sharing their feelings with others.

**Knocking on Doors**

In the current study active help seeking from family, friends, the lay community, and healthcare providers was identified as knocking on doors. Although some women found prompt and effective help, many women experienced asking for help as a stressful and repetitive activity frequently resulting in feelings of disappointment, frustration, and anger. This process was described by Beck (1993b) as “battling the system.” (p. 46).

**Expectations of Family and Friends**

The findings from this study are particularly interesting as they relate to women’s perceptions and beliefs about the ability of men to understand the experience of PPD. During Phase I of the help seeking process the women believed that men were unable to provide the understanding and support they needed. The women’s descriptions of male partners as clueless, confused, angry, and resentful were common. This finding is supported in data collected by Morgan, Matthey, Barnett, & Richardson (1997) who conducted interviews with male partners of women who were depressed. Men in this study consistently described feeling exasperated and resentful that their partners did not appreciate their practical assistance and suggestions. Morgan et al. concluded that practical help provided by men might actually increase women’s sense of guilt over their perceptions that they have failed to cope as mothers and concluded that emotional support, in the form of empathic listening, may need to precede instrumental support.

Findings from Badger’s (1996) grounded theory study that explored the experiences of 11 family members living with another family member who was depressed, provide considerable insight into the experiences of male partners and other family members of women who are...
depressed. Badger describes a process termed “fighting the battle” (p. 153) that consisted of fluctuating patterns of protective and coercive strategies in which family members attempted to deal with the interactional patterns that developed when one member of the family experienced depression. Protective strategies were designed to prevent the situation from getting worse and included affirming affection, suggesting alternatives, reducing conflict, seeking social support, and maintaining vigilance. Coercive strategies included avoiding interaction, demanding change, expressing emotion, threatening the relationship, and managing treatment. Findings from Badger’s study and findings from the current study suggest that as women try to survive the onslaught of depression by retreating into silence, others in their lives engage in their own struggle to try and make the situation better. Strategies used by the woman and those used by family members may act, in fact, as two opposing forces. The notion of these opposing forces is also alluded to in the work of Mauthner (1995) who suggests that social withdrawal and isolation are fundamental characteristics of depression and that this withdrawal is bound to affect the nature of women’s relationships. Mauthner described this as a reciprocal process in which women’s withdrawal from social contacts may actually reduce the likelihood of receiving support.

The women’s perceptions of men’s ability to help improved with the waning of symptoms. Practical help interpreted as intrusive and critical during the initial stages of the depressive experience became more acceptable and appreciated over time. As the women became less reliant on others and gained self-esteem they were more willing to accept instrumental support with household tasks and childcare provided by their partners and other family members.

Findings from the current study suggest that although women place a high value on their relationships with other women, particularly other women with children, they lack opportunities
to meet other women and share motherhood experiences. The value of these female relationships is supported in the work of Mauthner (1995) who found that mothers turned to other mothers with young children for psychological and emotional affinity and for relationships in which they could share common experiences including their struggle with depression. These same women spoke about difficulties meeting other mothers with young children due to lack of public places to “meet, mingle, and form and maintain friendships” (p. 34).

Loss of self-esteem and feelings of incompetence and inadequacy commonly experienced during depression, altered women’s perceptions of others. Many women in the current study believed that they did not measure up to friends and family members who were perceived to be perfect-mothers. Mauthner (1995) states that women in her study assessed their own behaviour in light of their perceptions of the moral good and right of normative views of motherhood. These women’s perceptions that other mothers felt comfortable in their motherhood role were often illusory, however. Coupled with increasing isolation during their depression these illusions were maintained by the fact that women frequently watched, looked and saw other mothers, but did not talk to them. Women in Mauthner’s study withdrew from these relationships, silenced their own voices, and became increasingly attuned to the moral voices of the experts and childcare manuals (p. 318).

Expectations of Healthcare Providers

Professional help seeking for women in this study began in Phase II of the help seeking process. Participants sought help from general practitioners, psychiatrists, PHNs, and counsellors when their symptoms became intolerable or when they perceived that their social network was unable or unwilling to cope with the problem. The notion that being disappointed with one’s social network or having symptoms that are intense and of long duration motivates professional help seeking is supported in the literature related to help seeking for other populations (Gourash,
Many women expressed disappointment and resentment that doctors and nurses failed to detect their depressive symptoms during home and clinic visits. They complained that clinic visits were short, rushed, and focused mainly on the health of the baby. The women were particularly upset that general practitioners and nurses did not ask questions related to maternal mood. The fact that only two women in this study were given a depression questionnaire to complete suggests that very few healthcare professionals use validated tools to screen for depression. As described in the literature review, the failure of healthcare providers to detect PPD is well supported in the research related to PPD (Almond, 1996; Holden, 1991; Horowitz et al., 1995; Mauthner, 1997). Findings from this study indicate that women's need to hide their depressive symptoms, and their inability to ask for help until they reach a crisis point, severely limits the ability of healthcare providers to detect PPD. If early recognition and detection of PPD leads to improved outcomes for women and their families, as the research literature suggests (Cox, Holden, & Sagovsky, 1987; Mauthner, 1997; Murray & Cooper, 1996), then healthcare providers who have regular contact with women during the postpartum period must improve their clinical skills in the detection of PPD.

The finding that women are frequently disappointed and angry at the manner in which healthcare providers treat them was also identified by participants in Steen’s (1996) study who described being patronized by doctors and rebuffed by experts who were insensitive to their needs. Similarly, women in Schreiber’s (1996) study described incidences in which healthcare providers misunderstood their situations and responded with judgemental attitudes. In the current study, listening, hearing, and validating were seen as key qualities of a helpful person by women who were reaching out for help for PPD. Schreiber described a process called “finding a sympathetic ear” (P. 479) in which women looked for validation and support for their feelings as
they sought out others to whom they could disclose their story. Schreiber identified the opposite of the sympathetic ear as "being misunderstood" (P. 479). Individuals who did not understand women's feelings or dismissed their complaints were not found to be helpful. Being judged and being misunderstood caused women to censor their stories.

Phase III: Tuning-in to Self

Findings from this study indicate that the process of reflection is a key component of the help seeking process for women who experience PPD. As symptoms subsided the women began a process of reflection in which they tried to find meaning in their experience. Reflection is a common theme in the literature that explores the phenomenon of recovery from depression (Peden, 1993; Schreiber, 1996; Unsworth, 1999). Schreiber describes this reflective process as "learning about my self" (p. 479) and suggests that recovering from depression involves a painful process of self-reflection in which women evaluate how they relate to the world and how their own behaviour may have contributed to their depression. This self-reflection leads to a sense of being "clued in," defined by Schreiber as emotional and cognitive knowing that helps women to make connections between what they feel and what they experience. Similarly, women in Peden's study described a process of reflection and evaluation that led to greater personal awareness and increased self-esteem. Wilkinson and Pierce (1997) found that the older adult women in their study viewed the experience of depression as an opportunity to know and understand themselves better and identified the act of self-reflection as a healthy component necessary to well being. In the current study, new insight gained from the reflective process provided the women with an ability to monitor their internal and external environments. The women used positive self-talk to bolster self-esteem and engaged in a process of monitoring thoughts and feelings to pick up early warning signs of relapse. Schreiber describes a similar phenomenon in which women in her study paid attention to their mood, analyzed why they might
have felt a certain way, and made conscious decisions to change, a process identified as monitoring and taking action.

Finding Strength Within

In retrospect many women in the current study found that the experience of depression provided them with an opportunity to learn more about themselves in a positive sense. This phenomenon is documented in other studies that explore the experience of depression in women. For instance, Schreiber (1996) found that women in her study were able to look back, reflect on where they had been, and appreciate where they were now. This process enabled women to find and incorporate the missing pieces of themselves and discard the "not me" (p. 486). Chernomas (1997) describes this same process as a struggle to make sense of unwanted and painful feelings leading to a healing of the self. Findings from the current study and findings from the research literature suggest that looking back for understanding, looking inward for strength, and moving forward in connection with others can lead women who have experienced depression towards healing and growth.

Summary

The findings in this study are substantiated by other studies about PPD and depression among the general population. The initial phase, identified as waiting to be rescued, was perceived by women as falling apart and described by them as emotionally, physically, and cognitively distressing. These findings are similar to findings presented by other researchers (Beck, 1992; Schreiber, 1996; Wilkinson & Pierce, 1997; Wood et al., 1997). The women in this study believed that there was nowhere to turn and consequently they suffered in silence. Active help seeking for PPD was preceded by a crisis event in which women could no longer tolerate the intensity of their symptoms. These findings are well documented by other researchers (Heifner, 1997; Jack, 1997; Mauthner, 1995; Schreiber; Steen, 1996). In the second phase of the
help seeking process, giving in and opening up, the women reported feeling inadequate as mothers and vulnerable to criticism from family members, friends, and healthcare providers. Women viewed the process of disclosing their thoughts and feelings to others as risky and their attempts to ask for help frequently left them feeling disappointed and angry with individuals who did not understand and systems that could not respond. This finding is similar to those by other researchers (Beck, 1993b; Mauthner; Morgan et al., 1997, Schreiber; Steen 1996). The third phase, tuning-in to self, represents a time of healing and renewal in which women reflected on their experience, looked inwards for strength, and moved forward by taking active steps to monitor and sustain their recovery. Self-talk and self-reflection were key strategies used by the women to bolster self-esteem, findings supported by Chernomas (1997), Peden (1993), Schreiber, Unsworth (1999) and Wilkinson & Pierce.

In general the research literature on help seeking for PPD and depression at other times in women's lives has focused on describing the experience and relating women's perceptions of the care they received from others. Findings from this study are significant because they provide a substantive theory on help seeking for women who experience PPD. This substantive theory broadens our understanding of this complex and distressing phenomenon that changes over time and in relation to the course of the depressive experience. To date, no other studies have identified a structured help seeking process that could provide guidance for nurses who care for women with PPD.
CHAPTER VI: SUMMARY, CONCLUSIONS, AND IMPLICATIONS FOR NURSING

This study provides a description of the help seeking process for women who experience PPD. The following discussion presents a summary of the findings for each phase of the help seeking process, the study conclusions, limitations of the study, and implications for nursing practice, education, and research.

Summary

PPD is a serious health issue that affects 13% of women worldwide and has serious consequences for women and their families. The purpose of this study was to explore women's experiences of seeking and receiving help from family, friends, and healthcare providers. This study comprises the first study of a four-part research study conducted in the FVHR of BC. Grounded theory methodology was used to guide this research study. This inductive approach examines the social context of human interaction (Talbot, 1995) and proved to be an effective and appropriate method to study the phenomenon of help seeking for women with PPD.

During the fall of 2000 and the spring of 2001 women who had experienced PPD were recruited into the study through newspaper advertisements and personal contact made by PHNs in the region. A total of 30 women agreed to participate and each woman attended one of six focus group sessions held at local health unit facilities. Over a period of 2 months audiotaped, semi-structured focus group discussions and participant observation field notes were completed and analyzed. The constant comparison method of analysis was used to identify themes in the data and to inductively derive patterns of help seeking behaviour. Data analysis involved the identification of common codes through a process of open coding followed by axial coding that identified emerging categories and grouped, linked, and condensed first level codes. Theoretical sampling was used to recruit new participants as themes emerged from the data. The final step in the analysis process consisted of selective coding in which all categories were unified around a
core category that represented the central phenomenon of the study.

Through this qualitative investigation an explanatory model of women’s help seeking behaviour for PPD was developed with *breaking the silence* emerging as the central category. Analysis of the data identified help seeking as a process consisting of three phases: (1) *waiting to be rescued*, (2) *giving in and opening up*, and (3) *tuning-in to self*. Waiting to be rescued constitutes the first phase of the help seeking process for PPD. As feelings of depression and anxiety begin, women sense that they are “falling apart.” The fear, loss, and shame that accompanies this depressive experience creates a situation in which women retreat into silence, being unable and unwilling to communicate their feelings and thoughts to others. As women wait to be rescued they engage in a process of *trying to survive*. Trying to survive represents an internal struggle consisting of four interconnected and alternating strategies described as: (1) *keeping the secret*, (2) *not wanting to think about it*, (3) *trying to analyze it*, and (4) *giving off signals*. This particular help seeking behaviour moves women into isolation and away from recovery. Women’s choice to wait and be rescued is influenced by an overriding belief that there is no one else who could possibly understand their unique situation. Asking for help for PPD carries a significant threat to women’s self esteem, particularly within a social, cultural, and political context in which individuals with mental illness experience stigma. The threat posed by the depressive symptoms is monumental and, consequently, protecting one’s self and the baby by withdrawing from social contacts is a defining feature of this initial phase of the help seeking process. *Reaching the end of the line* becomes a critical turning point in which women finally recognize the source of their distress. This moment of recognition provides the impetus to engage in active help seeking.

*Giving in and opening up* represents a time of active help seeking for women with PPD. As women give in to the likelihood that their distress may signal depression, they open up to the
possibility of asking for help. Giving in and opening up refers to a process of active help seeking consisting of three strategies: (1) putting self at risk, (2) knocking on doors, and (3) trying out options. Putting self at risk and knocking on doors describe help seeking behaviour that involves an assessment of which particular people are likely to be most helpful. This assessment takes into consideration the trustworthiness, knowledge, and attitudes of particular individuals and organizations. Putting self at risk and knocking on doors is frequently a cyclical process that involves constant evaluation. Trying out options refers to women’s particular behaviour related to accepting, evaluating, and modifying the treatments and suggestions provided. Expectations of family, friends, and healthcare providers contribute to the variability of women’s help seeking experiences. The perceptions and beliefs of women and their families influence treatment choices. As women open up and receive help from others symptoms begin to wane and they experience an increased sense of control over their lives.

Tuning-in to self refers to women’s active engagement in self-reflection, an activity in which women grieve for losses suffered and forgive themselves and others. As women engage in ongoing reflection they gain new insight into the nature of their depression as it is experienced within the context of their relationships with their infant, partners, families, friends, and healthcare providers. As women depend less on others, turn inwards for strength, and integrate the experience of PPD into their lives as partners and mothers, a new sense of self emerges. Gradually, healing and growth occur.

Breaking the silence emerged as the core category of this preliminary substantive theory on help seeking for PPD. The concepts of silence and voice are intertwined throughout all phases of the help seeking process. Suffering in silence is the defining feature of the initial phase of the help seeking process. Help seeking actions during this phase focus on hiding thoughts and feelings from others. Keeping silent is used as a protective strategy to protect women from the
criticism and judgement of others. In many cases male partners, family members, and healthcare providers facilitate women’s retreat into silence by ignoring signs of distress and failing to provide opportunities to engage women in dialogue. Halting the downward movement of the depressive experience is not possible until the women are able to call their depression by name. Putting words to the experience represents the first crack in women’s self-imposed silence. Speaking out and asking for help becomes a process of trial and error in which women carefully select who to tell, how much information to reveal, and how much information to conceal. As women begin to feel better they become more attuned to their inner voice and engage in a process of self-reflection, self-monitoring, and self-talk that finally leads them towards recovery. Breaking the silence represents women’s difficult journey from silence to voice.

Conclusions

The following conclusions made from this study are:

1. Help seeking for PPD is a process that consists of three phases: waiting to be rescued, giving in and opening up, and tuning-in-to-self.

2. Help seeking behaviour changes over time and is influenced by the trajectory of the recovery process. As depression sets in women suffer in silence; as women recognize the cause of their distress they reach out and ask for help; as women begin to feel better, they look inward for strength and reach out to help others.

3. PPD occurs within a social context of family and community that shapes women’s help seeking behaviour.

4. Women who have experienced PPD feel vulnerable to relapse.

5. The experience of PPD influences women’s decisions regarding future childbearing.

6. Early identification of women with PPD requires a unique set of clinical knowledge
and skills.

7. Validation, reassurance, empathic listening, and trust are key components of the helping relationship.

8. Women who have recovered from PPD have a keen desire to help other women in similar circumstances. Listening to the voices of these women and including them in program planning for other women who experience PPD will enhance the capacity of women to help each other.

Strengths and Limitations of the Study Method

Strengths of the Study Method

This four-part collaborative research project took place within the practice setting of public health nursing, providing a unique opportunity to link research and practice. Local media coverage for this project created considerable community interest, contributed to the successful recruitment of study participants, and increased public awareness about the issue of PPD. Although research within the community setting presents logistical challenges, these disadvantages were outweighed by significant benefits, including the successful recruitment of participants, the provision of learning opportunities for PHNs, hospital nurses, and other community service personnel, and the ability to share research costs. The community setting for this study allowed for the use of health unit facilities for focus group sessions in locations that were familiar to the participants and at no cost to the researcher. A particular strength of this project was the opportunity for informants to participate in more than one study. For example, approximately 15 women who participated in the focus group interviews in Study One also volunteered at a later date to be trained as peer volunteers for Study Four. In addition, two women who were pregnant at the time of the focus group sessions were able to participate in Study Two and Study Three after the birth of their infants.
The focus group approach to data collection provided opportunities for participants to connect with other women who had experienced PPD and many participants stated that the group discussions had been therapeutic. Focus group facilitation presented unique challenges for the researcher. Although I was a beginning researcher, new to the group interview process, I believe my sincere interest in the experiences of the study participants as well as my listening and organizational skills developed through my education and clinical nursing experience created an environment in which women felt safe to share their stories.

Limitations of the Study Method

Although consistent and intense effort was made to understand and analyse the data, the researcher’s inexperience with the process of qualitative research is identified as a limitation in this study. Learning to conduct qualitative research is challenging. As a novice researcher, data analysis became an all-consuming affair characterized by moments of incredible insight interspersed with overwhelming inertia. As time progressed, however, the process became more familiar and theoretical sensitivity towards the data increased. Theoretical sensitivity refers to the researcher’s awareness of the subtleties of meaning in the data (Talbot, 1995), or being able to see beneath the obvious and discover the new (Strauss & Corbin, 1998). Findings from this study are limited to the experiences and perspectives of this particular population at a particular time and are not generalizable to other populations.

Qualitative research requires an intricate interplay between the researcher and the data (Corbin & Strauss, 1990) and therefore I made a consistent effort to assess my own previously held views and biases. Although I am a mother of two adult children I did not experience PPD and consequently I do not have personal knowledge about this experience. My role as a PHN, however, has placed me in intimate contact with women who have experienced both mild and severe depressive symptoms in the postpartum period. Coincidently, during the course of this
research I also provided reassurance, support, and advice to close family members and friends who experienced similar symptoms to the women in this study, albeit outside the context of childbirth. Mauthner (1999) suggests that qualitative inquiry asks researchers to reflect upon and understand their own personal, political, and intellectual biographies and to make explicit where they are located in relation to their research participants. Throughout the conduct of this study I continually reflected on my personal feelings and beliefs that I acknowledge could have influenced the research findings. This practice of reflexivity was extremely helpful as I moved towards increased sensitivity to the meaning of help seeking for participants in my study.

A major threat to the quality of data using focus group interviews is the potential for participants to censor the views of less confident participants within the group (Sim, 1998) or for participants to conform to the dominant views of the group by participating in what has been called a “groupthink” (Carey & Smith, 1994, p. 125). In this study, however, the ebb and flow of the story telling process, the laughter, and the tears encouraged participants who may have been reluctant to participate to enter into the discussion. In all cases the participants showed great respect for individual differences in the experiences, perceptions, and opinions of others.

A limitation to the focus group approach is related to the tendency for a few group members to dominate the conversation thereby limiting the participation of other group members. Despite efforts to encourage equal participation of group members, it is possible that group members and the researcher may have been unduly influenced by other particularly articulate or vocal participants.

Implications

The findings of this study have implications for nursing practice, education, and research. An understanding of the unique help seeking behaviour of women in each phase of the process will assist healthcare providers to design and implement treatments and strategies that will help
women move through the phases of help seeking towards healing and growth. The following discussion focuses on the role of the PHN as it relates to women’s experiences of PPD within the cultural context of family and community. Public health nursing practice takes place within a variety of community settings and is focused on improving the health of individuals, families, groups, and the broader community. Consequently, PHNs are perfectly situated to take a leadership role in the provision of individualized care to women and their families, in the development of peer support opportunities aimed at assisting women to increase their capacity to help each other, and in the facilitation of broad community initiatives that will lead to increased public knowledge and awareness, and improved services and supports.

**Implications for Nursing Practice**

Help seeking for PPD is a dynamic and complex process. To support women who experience PPD PHNs need to increase their knowledge and understanding about the process of help seeking as it relates to the trajectory of the depressive experience. Attempts to increase knowledge and understanding begin with reflective practice and therefore PHNs who work with women in the perinatal period should ask themselves the following questions:

1. Does my current knowledge and skill level prepare me to assess maternal mood for women in the postpartum period?

2. Am I cognizant of women’s help seeking behaviours at different points during the depressive experience?

3. Does my current knowledge prepare me to plan and implement nursing care that addresses women’s needs as they relate to women’s help seeking behaviour at different stages of the recovery process?

4. Does my current clinical practice provide for safe, effective, and timely care for women who experience PPD?
5. Am I aware of knowledgeable community services and support for women and their families, and am I aware of existing gaps in services?

6. Am I listening to the voices of women? Are women who have experienced PPD included in the planning, development, and implementation of community programs?

7. Have I evaluated the care I am providing to women and their families as they relate to PPD in the areas of safety, effectiveness, and timeliness? Has my health region engaged in a program evaluation of existing services for women with PPD?

An understanding of the complex nature of women’s decision-making within each phase of the help seeking process identified in this study will provide guidance to nurses as they plan, implement, and evaluate nursing care. Women’s choices of when to seek help, whom to seek help from, and what kind of help to seek will differ within each of the phases.

Nursing Interventions for Women Who Do Not Ask for Help

The failure to assess and diagnose PPD leads to inadequate treatment (Horowitz et al., 1995; Mauthner, 1999). In the initial phase of the help seeking process women do not seek professional help specific to their depressive symptoms and consequently an assessment of maternal mood is a crucial element of the PHN postpartum assessment. The ability to make an effective assessment of maternal mood requires a wide range of interpersonal skills, clinical knowledge, acceptance of different cultural practices, and a clinical practice based on reflection (Thompson, 1997). Symptoms of PPD may be assessed through clinical observations or by the use of reliable and valid paper and pencil instruments. Due to the dynamic nature of the depressive experience and the process of help seeking, the timing of these nursing assessments for maternal mood is critical. Restricting assessments to telephone calls and visits that occur shortly after birth will result in a failure to recognize a significant number of women who experience PPD in later weeks or months. To develop programs that are responsive to the needs of women in the
perinatal period, PHNs must review current clinical practice in light of relevant research to
determine the most appropriate timing of these assessments. Program guidelines should then be
modified to reflect this new knowledge. It may be that PHNs will decide to develop programs
that provide multiple points and times of entry into health unit services for women with young
children.

Clinical assessment. A number of external signs may signal the presence of PPD
including: complaints of feeling low, worried, fatigued, having trouble sleeping; frequent
complaints of headache, abdominal pain or breast tenderness; expressed fear that healthcare
providers will be critical of one’s mothering ability; excessive concern over the health of one’s
baby; unexpected failure to attend clinic appointments or the presence of a baby that is not
thriving (Mauthner, 1997). During Phase I of the help seeking process women attempt to hide
their inner turmoil and therefore asking women vague questions such as “how are you feeling?”
will not provide an adequate assessment of maternal mood. Horowitz et al. (1995) suggest that
questions that may help to recognize depression need to be grounded in the behaviour and
statements of women such as, “I am worried about your inability to sleep” or “It is possible that
you are depressed?” Whenever a nursing assessment reveals feelings of depression, feelings of
being out of control, moderate to severe anxiety, fears or unrealistic concern, disordered
thinking, the potential for violence to self or others, or somatic complaints that are not consistent
with normal postpartum recovery, a consultation should be obtained from a mental health
clinician with expertise in evaluation and treatment of postpartum adjustment disorders
(Horowitz et al.).

Screening tools for PPD. Using validated screening tools can enhance an assessment of
maternal mood. Several different instruments have been used to screen for the presence of
depression. As cited in Horowitz et al. (1995) these are: the Beck Depression Inventory (BDI),
the Brief Symptom Inventory (BSI), the Center for Epidemiologic Studies Depression Scale (CES-D), the Depression Adjective List (DACL), the EPDS, and the Pregnancy and Postpartum Guidelines (SADS-PPG). Each of these tools has strengths and weaknesses and clinicians need to be trained in their use. In general, depression screening tools are quick and easy to administer and are well accepted by women. The use of a screening tool can provide women an opportunity to indicate how they are feeling during a time when they are most likely to remain silent. PHN teams should carefully review the advantages and limitations of various screening tools, select one that could be easily and accurately used within their public health nursing practice, and develop and implement a PHN training program to ensure the appropriate and effective use of such a screening tool. Screening programs that are developed must include documentation, tracking, and evaluation components. Early recognition and detection of PPD is complicated by women’s tendency to “wait to be rescued.” This behaviour forces women to wait until there is a crisis in which increasing intensity and duration of symptoms make help seeking mandatory.

Mauthner (1999) suggests that:

There may be a critical time of withdrawal and silence, which marks the transition from feelings of low mood and sadness to feelings of depression. If health providers and mothers are aware of this critical period and if mothers are encouraged to speak about their feelings early on, and provided with a supportive, non judgemental and accepting relational context within which to do so, PPD might be prevented. (p. 158)

It is possible that nursing interventions focused on early recognition and early support could actually prevent PPD, however further research in this area is needed.

Nursing Interventions for Women Who Ask for Help

The occurrence of a critical turning point in which women’s symptoms become intolerable precedes cognitive recognition of the presence of depression. This moment of recognition prepares women to ask for help and provides a unique opportunity for PHNs to intervene. Currently, PHNs should inform women that many new mothers feel depressed after childbirth
and that this does not mean she is bad or weak. In addition, it is critical that PHNs reassure each women that she is not crazy, that there are effective treatments and supports available, and that she will get better in time. This may also be a good time to show her some written information about PPD, to recommend that she talk to her doctor or mental healthcare professional, and encourage her to talk to a trusted family member or friend.

As women recognize and name their depression they begin to open up and reach out for help. At this point in time PHNs can play a key role in helping to connect women to community services. PHNs should be familiar with support groups, publications, mental health agencies, and other community services for women with PPD. Knowledge of these resources includes information on availability, location, and cost. PHNs may also provide ongoing follow-up with home visiting or telephone contact. Many women in this study were extremely thankful for nurses that gave of their valuable time to visit on a regular basis and to "be like a friend."

Listening is a key component of all PHN nursing interventions. Women who experience PPD are particularly sensitive to what they perceive to be criticism and consequently the quality of the relationship between the PHN and the new mother is central to the provision of therapeutic and effective nursing care. PHNs must recognize the unique circumstances of each woman and create a trusting environment in which women understand that feelings of ambivalence, distress, and depression are both accepted and acceptable. A nonjudgemental attitude facilitates the development of an environment in which women feel safe to share their thoughts and feelings.

PPD occurs within an intricate social network and many family members also experience significant distress when their partner, daughter, or mother is depressed. Home visits provide an opportunity to assess women within the context of the home and family. Women and their partners frequently experience communication difficulties during the postpartum period and consequently, PHNs should attempt to plan postpartum home visits when partners can
participate. If agreeable to the mother, PHNs can help to open up the conversation for the couple and provide information about common communication difficulties experienced by other families. PHNs can also explore the role of the social network in the decision to seek help.

Findings from this study indicate that the perceptions, values, and beliefs of family members have a strong influence on women's treatment choices and therefore it is particularly important for PHNs to engage women and their family members in discussions about treatment options. Male partners may fail to understand the true nature of the depressive experience and consequently, they will benefit from a frank discussion about the nature of PPD. If agreeable to the mother, the involvement of other trusted family members should also be encouraged.

Pamphlets that review common feelings experienced by women after the birth of a baby and suggestions about what to do when women feel depressed should be reviewed with families.

As women begin to feel better they draw on inner strength to make meaning of their experience. Interventions during this final phase of the help seeking process need to focus on providing ongoing support and encouragement by telephone, at health unit clinics, or through home visiting. All of the women in this study participated for the specific purpose of helping others. PHNs can play a major role in improving the capacity of women to help each other. PHNs can initiate and facilitate the development of community action groups aimed at increasing public awareness of this serious health issue for women and their families. Community development strategies that use a multidisciplinary approach and that involve women in the planning, implementation, and evaluation of community education and support programs should be encouraged. In this way PHNs can help to break the silence that pervades much of the care provided to women who experience PPD.

**Implications for Administration**

Health region policies, particularly regarding the method of delivery of postpartum care
in the community, can affect the ability of PHNs to assess for PPD and provide safe, effective, and timely care for women and their families. Administrators need to review the practicality of implementing a PPD screening program and encourage broad-based community strategies aimed at increasing the knowledge and understanding of all parties. The resource implications of delivering an effective PPD screening and treatment program are potentially large and daunting (Fuggle & Haydon, 2000). Research is available that examines the cost effectiveness of PPD screening and treatment programs. For example, in a small pilot project aimed at assessing the resource and organizational implications for such a program, Fuggle and Haydon found that PPD screening and brief counselling visits by health visitors led to improved outcomes for clients and enhanced professional responsiveness with a relatively modest training investment. Administrators can also develop linkages with community mental health facilities and local psychologists, psychiatrists, and counsellors to provide PHNs with expert help and support.

Implications for Nursing Education

PHNs need to increase their knowledge and understanding about the experience of PPD and women’s help seeking behaviour by reading journals, sharing with colleagues, attending conferences, and enrolling in courses. PHNs who work with women who experience PPD and their families need to understand the nature of the depressive experience and how to assess, plan, intervene, and evaluate their clinical nursing practice. In BC, all PHNs have baccalaureate degrees in nursing which provide them with a broad knowledge of the physical and psychological adjustment to parenthood. Depending on experience and interest, however, PHNs may need more in depth knowledge of mental illness and appropriate intervention approaches. Educational strategies need to be developed at all levels of nursing training, including basic and master’s programs, and continuing education. Curricula need to focus on information related to
the physical and emotional transition to motherhood, perinatal maternal and infant assessment, breastfeeding, community visiting, concepts of self and loss of self, cultural differences in women's experience of childbirth and depression, and mental health assessment. Knowledge and skill development for nurses can be facilitated through practicum experiences at mental-health facilities, self-help groups, peer-support groups, and public health units. Continuing education committees could sponsor multidisciplinary community education forums involving presentations by community experts and women who have experienced PPD. Graduate nursing schools should focus on knowledge and skill development in the area of policy and program development, the role of women in society, feminist and critical theory perspectives, and research. Educational institutions might also want to consider establishing advanced skill training for clinical nurse specialists in the area of perinatal maternal mental health. PHNs could engage in local training opportunities for PPD support group facilitation or develop such training programs within their local health regions. PHNs also need access to conferences, newsletters, and websites at both academic and work sites.

**Implications for Nursing Research**

This substantive theory contributes to the understanding of the process of help seeking for women with PPD. The phases of the help seeking process identified in this study provide a preliminary view of women's help seeking behaviour as they wait to be rescued, give in and open up, and tune-in to self. Further studies could expand this theory by examining the process with different populations. Although there was a diverse representation of participants with respect to age, parity, education, and income, all but two of the women in this study were Caucasian. Only two participants were of Aboriginal heritage and no woman of South Asian heritage volunteered to participate, despite the large South Asian population within the FVHR. Subsequent studies could explore the process of help seeking for PPD for women of different
cultures using recruitment strategies that are sensitive to the issues of daily life for these women.

The large number of women in this study who experienced postpartum anxiety and panic suggests that further research should examine this experience. Related research questions could include: How do women's descriptions of panic in the postpartum period differ from their descriptions of panic at other times in their lives? What is the prevalence of panic accompanied by depression in the postpartum period? How do women's help seeking behaviours differ for those who experience panic and those who do not? What nursing interventions can be used to best support women who experience panic and depression following childbirth?

Another phenomenon of interest is the experience of women who do not seek professional help for PPD, a process described in this study as “going it alone.” What is the difference in the experiences of women who seek help for PPD and those who do not? What is the nature of the experiences of women who do not seek professional help for PPD? Do women who do not seek help for PPD successfully help themselves? Two thirds of the women in this study used antidepressant medications to treat their depressive symptoms and nine women were taking these medications at the time of the focus group interviews. Further studies are needed to explore the experience of help seeking for women who choose not to use medications.

PPD occurs within a unique social and community context and findings from this study illuminate the far reaching effects for women and their families. Qualitative studies exploring the experiences of male partners and other family members of women with PPD would further broaden our understanding of the nature of depression as it affects families. Further studies also need to be conducted that examine the effects of peer support on depressive symptomatology. Provincial, national, and international surveys that identify the structure and function of existing public health nursing programs aimed at providing care to women with PPD would be beneficial.
In addition, evaluation studies to determine the appropriateness, acceptability, and cost-effectiveness of these community programs and services are needed.

Summary

For women in this study PPD occurred within an intricate social context that included a unique dyadic relationship with their babies. Help seeking was identified as a difficult and complex process consisting of three phases and women’s choices of when to seek help, who to seek help from, and what kind of help to seek differed within these phases. This preliminary substantive theory illuminates the complexity of women’s responses to PPD and provides guidance for nurses who seek to improve the health of women and their families. The women in this study told us that they felt silenced. *Breaking the silence* emerged as the core category and refers not only to the fundamental need for women to break their self-imposed silence, but for family members, healthcare providers, and the larger community to do likewise.


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Appendix A: Collaborative Research Project

Mothers Helping Mothers with Postpartum Depression Research Project

This qualitative study is part of a larger collaborative research project conducted in the Fraser Valley Health Region (FVHR) to explore and examine postpartum depression (PPD). BC Ministry for Children and Families' Make Children First Initiative and the FVHR Prevention and Early Intervention Program (PEI) provided funding support for the project. Dr. Cindy-Lee Dennis and two public health nurses who were completing their master's theses co-ordinated all research activities with support from Margaret Gander, Regional Director, PEI and Patricia Whitehead, Public Health Nurse Manager, Mission and Hope. The primary goal was to conduct research that would provide the FVHR with empirical findings to assist in the development of appropriate, effective, and efficient healthcare services for women with PPD. A secondary goal was to develop collaborative research links between the FVHR and researchers at the University of British Columbia (UBC) Faculty of Medicine and the UBC School of Nursing.

Overall Project Objectives:

1. To understand women’s experiences of seeking and receiving help for PPD in the FVHR.
2. To determine the prevalence of mothers identified to be at high risk for PPD in the FVHR
3. To evaluate the Edinburgh PPD Scale (EPDS) for its predictive power (including the relationship between antenatal and postnatal scores) and feasibility for its formal use within the region’s general PHN practice.
4. To develop a multifactorial predictive model of PPD.
5. To determine the relationship between childbearing women’s social and spiritual resources and the development of PPD.
6. To pilot test a peer support intervention for women identified to be at high risk for PPD.
Study One

*Women's Experiences of Seeking and Receiving Help for Postpartum Depression*

**Research Question**

What are women’s experiences of seeking and receiving help for PPD?

**Research Design**

In this study the methods of grounded theory were employed using focus group interviews with women who experienced depression in the postpartum period. This method was chosen because of its appropriateness in studying the dynamic process of seeking and receiving help.

**Data collection**

Two, 2-hour focus group sessions, consisting of 6-8 participants each, were conducted in each of the four participating communities; sessions were audiotape recorded and transcribed verbatim, masking names of participants, moderators, and communities.

**Participants**

Women who lived in the FVHR and had experienced PPD were recruited into the study. Specific inclusion criteria included maternal age of 18 years or older and ability to read or understand English. Recruitment occurred through newspaper articles and posted flyers in community facilities. Theoretical sampling was used to gain a sample of 30 women.

**Data Analysis**

Descriptive statistics were completed on demographic variables and data were analysed to inductively derive patterns and themes using the qualitative techniques of constant comparative methods. The theory derived from the data offers insight, increased understanding, and provides guidance for action.

**Contributions:** This study was intended to:

(1) Provide a substantive theory of help seeking for PPD to guide nursing practice,
administration, education, and research.

(2) Provide data to assist in the development of a peer-support intervention study

Study Two

Postpartum Depression: Prevalence, Risk Factors, and Early Intervention

Research Questions

(1) What is the prevalence of mothers identified at risk for PPD on the EPDS?
(2) What are the predictor variables of mothers identified at risk on the EPDS (score ≥10)?
(3) What is the relationship between antenatal and postnatal EPDS scores?
(4) What is the reliability and validity of the EPDS?

Research Design

In this longitudinal study, mothers completed questionnaires at four time intervals: prenatally (T1) and at 1 (T2), 4 (T3), and 8 (T4) weeks postpartum.

Sample

The target population consisted of all women who met the following criteria: (a) ability to read or understand English; (b) age > 18 years; (c) residence in the FVHR, and (d) no history of a postpartum psychosis.

Data Analysis

Univariate and multivariate analyses were conducted.

Contributions: This study was intended to:

(1) Determine the prevalence of mothers at risk for PPD in the FVHR.
(2) Provide a multifactorial model to predict PPD.
(3) Assess the predictive power of the EPDS.
(4) Explore the feasibility of using the EPDS as a community-screening tool for PPD in general PHN practice.
Study Three

The Relationship between Postpartum Women's Social and Spiritual Resources and the Development of PPD: A Prospective Study

Research Hypotheses

Social and spiritual resources were hypothesized to have both direct and indirect effects on depressive symptoms at eight weeks postpartum. (Women's social resources included social support and conflict within specific close interpersonal relationships; women's spiritual resources included variables representing multiple dimensions of religiousness/spirituality.) Mediating variables in the model were global perceived social support and self-esteem, conceptualized as women's "inner-self resources" (cognitive working models of self-in-relation-to-others and self-identity).

Research Design

This was a prospective design. Data from questionnaires women completed at 2 and 8 weeks postpartum in the final 4 months of Study Two were used.

Sample

The sample was a subset of the women in the target population described in Study Two and consisted of all women who were recruited in the final 4 months of the study.

Data Analysis

Path analysis was used to test the model of the influences of postpartum women's social and spiritual resources on the development of depressive symptoms at 8 weeks postpartum.

Contributions: This study was intended to:

1. Provide knowledge about the spiritual dimension of postpartum women's experience contributing to a holistic approach in assessment and interventions in PPD.

2. Provide knowledge about how the quality (conflict and support) of specific interpersonal
relationships influences the development of PPD.

3. Increase theoretical understanding of mechanisms through which women's social and spiritual resources affect the development of depressive symptoms in the postpartum period.

Study Four

Postpartum Depression: Evaluation of a Psychosocial Intervention Among Mothers Identified at High-Risk

Primary Research Question

What is the effect of peer support on PPD among mothers identified to be at high risk for PPD?

Research Design

In this pilot, randomized controlled trial (RCT), mothers identified to be at high risk for PPD at 8 weeks postpartum were randomly allocated to receive either conventional care or peer support.

Sample

The target population consisted of all women who met the following criteria: (a) ability to read or understand English; (b) age > 18 years; (c) scored ≥ 10 on an 8-week EPDS assessment; (d) residence in the FVHR, and (e) no history of a serious psychiatric disorder or postpartum psychosis.

Data Analysis

Univariate and multivariate analyses were used to examine differences and trends between groups; these analyses were used to guide the development of a statistical plan for a larger trial.

Contributions: This study was intended to:

(1) Contribute to the body of knowledge on the effect of a psychosocial intervention in the treatment of PPD.

(2) Advance our understanding of the advantages and disadvantages of using lay helpers as a complementary form of healthcare and as mediating links between healthcare providers and clients in the community.
(3) Guide the development of a CIHR proposal for a larger randomized controlled trial that will evaluate the effect of a psychosocial intervention on PPD among high-risk mothers.
Public Health Nurses in the Fraser Valley Health Region and researchers from the University Of British Columbia are conducting a research study on postpartum depression.

If you experienced depression after having a baby, we would like to hear your story. Focus groups will be held in your community in March and April 2001.

For More Information
Contact
Public Health Nurse
Mission Health unit
(604) 814 5500

Mothers Helping Mothers with Postpartum Depression Research Project
Appendix C Introduction To Prospective Participant

**Title of Research Project:** Mothers Helping Mothers With Postpartum Depression

**Study One:** Women’s Experiences of Seeking and Receiving Help For Postpartum Depression

Researchers from the University of British Columbia have joined together with Public Health Nurses in the Fraser Valley Health Region to conduct a study about postpartum depression. The purpose of this study is to find out what it is like for women who feel depressed after the birth of their baby. It is important to understand women’s experiences so that the region can provide better care for women and their families.

If you experienced depression after the birth of a baby and would like to participate in this study we would like to know what this experience was like for you. In particular we would like to know who you talked to, what kind of help you asked for, what kind of help you received, and what that help was like.

The researchers would like permission to contact you to explain the study in more detail. The fact that you agree to be contacted does not mean you are consenting to participate in the study but that you would like to hear more about it. If you do not wish to be involved in the study there will be no risk to you or your access to health services now or in the future. No names will appear in any written reports or in the final thesis paper.

If you are INTERESTED in hearing more about the study, thank you very much. A researcher will telephone you within the next couple of weeks.

If you are NOT INTERESTED in the study, that is fine. Would you mind telling us why? It would help the researchers to know the reason why women are not interested in their study.

Thank you for your time.

To be completed by the Public Health Nurse

Date: PHN

☐ Participant verbal consent OBTAINED, the researcher MAY contact potential participant
☐ Participant verbal consent NOT OBTAINED the researcher MAY NOT contact potential participant.

Mother’s: Name: Age: Telephone:

Residence: Chilliwack Hope Mission Abbotsford Agassiz Boston Bar
Ethnicity: Caucasian Asian other:
Parity: Primiparous Multiparous
Appendix D: Study One Introductory Letter Of Explanation

**Title of Research Project:** Mothers Helping Mothers With Postpartum Depression

**Study One:** Women’s Experiences of Seeking and Receiving Help For Postpartum Depression

My name is Pam Munro and I am a student in the Master’s of Nursing Program at the University of British Columbia. For the last nine years I have been a public health nurse in Maple Ridge and have worked closely with new moms and babies. For my Master’s thesis I will be conducting a study that explores women’s experiences of postpartum depression. This study will be Phase I of a four-part research project designed by Dr. Cindy-Lee Dennis and conducted in partnership with Public Health Nurses in the Fraser Valley Health Region and researchers from the University of British Columbia.

The purpose of this study is to find out what it is like for women who feel depressed after the birth of their baby. In particular the researchers want to know if women told anyone that they were depressed, and if so, who did they tell. The researchers also want to know what kind of help women received from family, friends, and healthcare providers and what this help was like. It is important that we listen to women’s voices so that we can gain a better understanding about postpartum depression and provide services and resources that were helpful to women and their families.

If you agree to take part in this study you will attend a two-hour focus group in your community with five to seven other women who have also experienced depression after having a baby. During focus groups a researcher will ask the group questions about experiences that they have had in common. All members of the group are encouraged to respond to the questions and engage in a discussion about the issues that come up but are not required to answer any questions that make them feel uncomfortable. In order to keep track of what is being said focus group discussions will be audiotape recorded. All information collected is strictly confidential. Your name and any identifying information will remain confidential and will not be used in any written report of the study. The data records will be kept on a computer disk and stored in a secure file with password access. A summary of the study findings will be made available to you at the end of the project, if you request it.

If you decide not to participate in this study there will be no effect on your use of health services now or in the future. If you agree to participate you may withdraw from the study at any time. There may be no known benefits to you as a participant in this study but there may be
changes to the care that other women with postpartum depression receive. At the end of each session refreshments will be provided as well as an opportunity to meet with the other group participants.

If you would like to participate in this study or would like more information, please feel free to contact me by leaving a message with the Public Health Liaison Nurse in your community (see numbers below). I will call you back as soon as possible. Professor Roberta Hewat is also available to answer any questions you may have.

Thank you for your consideration.

Pam Munro, R.N., BScN
Student, Master’s of Nursing Program
University of British Columbia School of Nursing

Public Health Liaison Nurse
Abbotsford PHN Liaison 864 3400
Mission PHN Liaison 814 5500
Chilliwack / Agassiz PHN Liaison 702 4900
Hope / Boston Bar PHN Liaison 869 5661

Roberta Hewat, RN, PhD
Thesis Committee Chair
UBC School of Nursing
604 622 7464

Cindy-Lee Dennis, RN, PhD
Principal Investigator Four-Part Project
UBC Faculty of Medicine
604 875 2000 ext 6535
Appendix E: Consent Form

Title of Research Project: Mothers Helping Mothers With Postpartum Depression

Study One: Women's Experiences of Seeking and Receiving Help For Postpartum Depression

Principal Investigator: Pam Munro, R.N., BScN, MN(c), UBC School of Nursing

I understand that I have been asked to participate in a focus group with other women who have experienced postpartum depression. The information from the focus group will be used to assist the researcher to understand mothers' experiences of postpartum depression.

I understand that during the focus group I, along with other group members, will be asked specific questions and that if I feel comfortable, I may share my opinions. The focus group will take approximately 2 hours to complete and will be audiotape-recorded for transcription purposes only. The tape-recorded material will be shared with members of the thesis committee only and the tapes will be erased immediately following completion of the study.

The confidentiality of any information resulting from this group discussion will be strongly enforced. All documents will be identified only by code number and kept in a locked filing cabinet. No names will appear in any written reports or in the final thesis paper. The data records will be stored on a computer disk and will be kept in a secure file with password access only. A summary of the study findings will be made available to me if I request it, at the end of the project. The results of the study may be published or presented at conferences to share the new knowledge and understanding with others.

If I have any questions or desire further information with respect to this study, I may contact Pam Munro by leaving a message at the Mission Health unit (604) 814 – 5500. If I have any concerns about my treatment or rights as a research participant I may contact the Director of Research Services at the University of British Columbia, Dr. Richard Spratley at 822-8598 or Dr. Roberta Hewat, Thesis Supervisor at (604) 622 7464

I understand that my participation in this study is entirely voluntary and that I may refuse to participate or withdraw from the study at any time. Any decision to withdraw or terminate my participation will not jeopardize my access to any healthcare services now or in the future.

I have received a copy of this consent form for my own records.

I have read the above statements and consent to participate in this study.

Signature of Participant ___________________________ Signature of Witness ___________________________

Signature of Researcher ___________________________ Date ___________________________
Title of Research Project: Mothers Helping Mothers With Postpartum Depression

Study One: Women's Experiences of Seeking and Receiving Help For Postpartum Depression

Thank you very much for participating in today’s focus group. At this time I would like to ask a few questions about your experiences of postpartum depression and some information about your background. Your answers to the following questions would be greatly appreciated. You do not have to answer any questions that make you feel uncomfortable. You do not need to put your name of this form.

How many children do you have? (Please circle)

1. One
2. Two
3. Three
4. Four or more

What are the ages of your children? ___________________________________________________________________

How old are you? __________

After which of the following events did you feel depressed? (Please circle all that apply)

1. The birth of my first child
2. The birth of my second child
3. The birth of my third child
4. The birth of my fourth / or subsequent child

During the time that you experienced postpartum depression what was your marital status?

1. Married / Common-law
2. Single / never been married
3. Separated / Divorced
4. Widowed

What is the highest level of education you have completed?

1. Elementary school
2. High school
3. College/ Trade School
During the time that you experienced postpartum depression what was your annual household income before taxes? (Please circle)

1. $0 - 19,999
2. $20,000 - 39,999
3. $40,000 - 59,999
4. $60,000 - 79,999
5. $80,000 - +

Were you born in Canada? (Please circle)

1. Yes
2. No

Which of the following best describes you? (Please circle)

1. White
2. First Nations (e.g. North American Indian, Inuit)
3. Metis
4. Chinese
5. South Asian (e.g. East Indian, Pakistani, Punjabi, Sri Lankan)
6. Arab/West Asian (e.g. Armenian, Egyptian, Iranian, Lebanese, Moroccan)
7. Filipino
8. South East Asian (e.g. Cambodian, Indonesian, Laotian, Vietnamese)
9. Latin American
10. Japanese
11. Korean
12. African/African American
13. Other (please specify) ________________________________

How did you know you had postpartum depression? ________________________________

When did you first realize you were depressed? ________________________________
Did you experience depression before you had children? (Please circle)

1. Yes
2. No

Did you experience depression during pregnancy?

1. Yes
2. No

Did you seek help for your depression? (Please circle)

1. Yes
2. No - Can you tell me why not? ____________________________________________

Did anyone encourage you to seek help for your depression? (Please circle)

1. No, I decided myself.
2. Yes – my partner
3. Yes – other family member
4. Yes – a friend
5. Yes – other ____________________________________________

For those of you who did not seek help for your depression please go to question # 20.

If you did seek help, what was the reason you asked for help? __________________________

Who did you seek help from? (Please circle all answers that apply)

1. My partner
2. Other family member
3. Friend
4. Family Physician
5. Public Health Nurse
6. Other ____________________________________________

What help did you receive? (Please circle all answers that apply)

1. Just talking to family and friends
2. Professional Counselling
3. Support Group
4. Antidepressant Medication

5. Other: Explain

Did the help that you received make you feel better? (Please circle)

1. Yes

2. No – Why do you think the help you received did not make you feel better?

Is there anything else you would like to tell me about yourself?

Why did you want to participate in this research?

THANK YOU: Your time and contribution to this research activity is sincerely appreciated.
Title of Research Project: Mothers Helping Mothers With Postpartum Depression

Study One: Women’s Experiences of Seeking and Receiving Help For Postpartum Depression

1. Warm-up and Explanation (10 minutes)
   - Introduction
   - Thanks for coming
   - Your presence is important – explain study.
   - Describe what a focus group is
   - Discuss confidentiality issues- strongly encourage confidentiality of information disclosed by the group members

Purpose
   - We will be discussing your experiences of seeking and receiving help for postpartum depression.
   - I am interested in all your ideas, comments, and suggestions.
   - There are no right or wrong answers.
   - All comments, both positive and negative, are welcome.
   - Please feel free to disagree with one another. We would like to have many points of view.

Procedures
   - (Explain use of audiotape). All comments are confidential, used for research purposes only.
   - I want this to be a group discussion, so you needn’t wait for me to call on you. Please speak one at a time, so that the tape recorder can pick up everything.
   - We have a lot of ground to cover, so I may change the subject or move ahead. Please stop me if you want to add something.
Self-Introductions: (Ask each participant to introduce herself). Tell us your first name and briefly say something about yourself.

2. General Perceptions of Postpartum Depressions

- When you think about postpartum depression what is the first thing that comes to your mind?

3. Recognition and Detection

- How did you know you were depressed?
- Think back to when you first realized there was a change in yourself. What was that like for you?
- Did anyone else notice a change in you? Family? Friends? Providers?

4. Perceptions and Beliefs

- What do you think contributed to your depression?

5. Help-Seeking Behaviours

- How did you decide whom to tell or not tell?
- How did people react when you told them about your depression?

6. Treatment and Intervention Preferences

- What kind of help did you get?
- Probing Questions: from family, friends, providers, others?
- Who was most helpful? Please tell me about that.
- Who was the least helpful? Please tell me about that.
- What advice would you have for other women in the same situation?

7. Closing
Title of Research Project: *Mothers Helping Mothers With Postpartum Depression*

**Study One: Women's Experiences of Seeking and Receiving Help For Postpartum Depression**

Principal Investigator Study One: Pam Munro, R.N., BScN, MN(c), UBC School of Nursing

Dear: _______________________

With this letter I am asking you to provide feedback on a form that will be used in Phase I of a four-phased research project being conducted by researchers from UBC and Public Health Nurses in the Fraser Valley Health Region. The purpose of this study is to explore women's experiences of seeking and receiving help for postpartum depression.

In this study women who have experienced postpartum depression will be invited to participate in focus groups sessions. At the conclusion of each session, participants will be asked to complete a demographic form that will provide information that will be used to describe the study participants. The questions should take about five minutes to complete and women will be asked not to write their names on the form.

It is important that this tool is clear, simple, and easy to use. Your feedback on this form would be appreciated.

Please turn to next page for instructions.

Yours truly,

Pam Munro,