Young Aboriginal Mothers’ Postpartum Experiences

by

Hazell Patricia Penn
BSN, University of Victoria, 2002

A Thesis Submitted in Partial Fulfillment of the
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Supervisory Committee

Dr E. M. Banister, (Department of Human and Social Development)

Supervisor

Dr K. Mackinnon, (Department of Human and Social Development)

Departmental Member

Dr W. A. Bruce, (Department of Human and Social Development)

Departmental Member

Dr J. Ball, (Department of Human and Social Development)

Outside Member
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Outside Member

Abstract

An ethnographic method was used for data collection and analysis. Three interrelated themes from the data analyses informed study findings: (1) being cut off from family and feeling lonely, (2) what’s the point? and (3) not depression, just depressed. Understanding young mothers’ depression after the birth of their babies is important to inform future research and gain insights into relevant nursing interventions for this population. More knowledge of the phenomenon will lead to earlier identification and prevention of the long-term sequelae of depression and potentially promote healthier mother-baby interactions.
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CHAPTER ONE:
INTRODUCTION

The intent of this study was to advance knowledge of the postpartum experiences of young Aboriginal mothers. This ethnographic study explored the central question, How do young Aboriginal mothers experience the postpartum period? Little is understood about the experience of depression in adolescence generally, and even less in young motherhood (Cicchetti & Toth, 1998; McHenry, Browne, Kotch, & Symons, 1990), particularly among the Aboriginal population. In Canada, adolescent fertility in the non-Aboriginal population has been decreasing while it is increasing in the Aboriginal population and now stands at an eight times higher fertility rate among Aboriginal girls. The Aboriginal population has grown by 45 per cent since 1996, outpacing the eight per cent growth in the non-aboriginal population (Statistics Canada, 2006). In exploring the phenomenon of postpartum depression (PPD) among Aboriginal young mothers, I hoped to show patterns that would represent the taken-for-granted, day-to-day experiences that have particular meaning to them. My intention as an ethnographer was to enhance the understanding of the phenomenon of PPD from the perspective of the mothers themselves and to educate healthcare providers by contributing to the literature on this topic.

Statement of the Problem

continues to affect women's mental health and their ability to develop attachments to their infants (Beck, 1998b). Research on PPD in younger Aboriginal mothers is very limited (Smylie, 2003). Because little is known about the phenomenon of PPD in this age group of Aboriginal mothers there is a need to give them a voice to improve the policies and practices that are affecting their lives.

Purpose of the Study

The purpose of this study was to develop knowledge of the postpartum experiences of young Aboriginal mothers to shed light on this phenomenon. Little is known about the phenomenon of PPD in young Aboriginal mothers generally, but some literature has acknowledged that the presentation of PPD is somewhat ambiguous in young mothers and that, conceivably, PPD remains largely undiagnosed in this cultural group (Dion-Stout & Stout, 2001). It is conceivable that it exists at the same high rates in this population as the literature has reported for young mothers in the general population.

Background and Rationale for the Study

PPD is deemed to occur across all cultural groups, yet many new mothers are unlikely to seek treatment for mental health issues (Flynn, Davis, Marcus, & Blow, 2004). Because many women do not choose to access care, detecting and treating PPD is difficult to achieve (Kirmayer, 2000). The intent of this study was to highlight the postpartum experiences of a small group of young Aboriginal mothers who may be suffering from PPD and not receiving the care and attention that this condition warrants.

Overview of the Methodology

I chose to use elements of ethnography to gain an understanding of young Aboriginal mothers' experience of the postpartum period. Ethnography is a qualitative research method that aims to seek "emic, or contextual, situated understandings" (Denzin
& Lincoln, 1994, p. 506) to describe a culture. An ethnographic study begins with the identification and observation of people who form a culture-sharing group (Spradley, 1980) in this case, young Aboriginal mothers. This small scale study used elements of ethnography such as the use of interviewing and participant observation for gathering data. Such procedures were used to document the post partum experiences of three women, to describe their everyday lives, and to explore the social meaning behind their descriptions (Spradley, 1979; Mason, 2002).

My approach to this study was influenced by a constructivist worldview (Guba & Lincoln, 2005, p. 203). Within the constructivist paradigm it is acknowledged that many shared realities exist and this allows the researcher to explicate the effects of "social, cultural, and historical context" (p. 24) on the participants' lives. This paradigm assumes relativist ontology with multiple realities whereby the knower and the researcher co-create meaning and understandings (p. 51). This study worked to understand the participants' cultural reality and describe their experiences of being young Aboriginal mothers.

The complexity of research with Aboriginal people (University of Victoria, 2003) is acknowledged in the methodological choices and procedural methods of this research study. The research respected and protected the interests of the Aboriginal participants by using transparent methods and fully informing the participants about all aspects of the research process from beginning to end.
CHAPTER TWO:

LITERATURE REVIEW

Postpartum Depression

Postpartum depression is a form of clinical depression affecting women after childbirth. It is characterized by depressive episodes and a number of symptoms including: depressed or sad mood, plus a marked loss of interest in virtually all activities. Although mood disorders are known to be common in pregnancy and the postpartum period the characteristics of postpartum depression are ambiguous (Jones, 2006).

Predictors, Prevalence, Timeframe, and Effects of Postpartum Depression

Women most commonly experience depression during their primary reproductive years and are especially vulnerable to developing depression during pregnancy and after childbirth (Beck, 1996; Beck, 2002; O’Hara & Swain, 1996). The formal classification system used in North America is the American Psychiatric Association (APA) Diagnostic and Statistical Manual of Mental Disorders, Fourth edition, or DSM-IV (American Psychiatric Association, 1994. The DSM-IV criteria of PPD include a specifier that the symptoms occurred within four weeks of the woman having given birth.

Many clinicians suggest that a woman with postpartum depression may exhibit five or more of the following symptoms for a two-week period or experience depressed mood for a period of at least two weeks at some stage during the first nine months postpartum (Beck, 2001b; O’Hara & Swain, 1996; Wisner, Parry, & Piontek, 2002). Individuals must have exhibited either a depressed mood or a loss of interest or pleasure, for a minimum of two weeks. In addition, they must have experienced other symptoms from a given list of seven, for a minimum of two weeks. A clinician will diagnose major
depression if the individual has a low mood, plus four other symptoms (for a minimum of five symptoms). Women with a low mood with fewer than four symptoms will receive a diagnosis of minor or moderate depression. The symptoms of PPD are: weight changes; appetite changes, sleep disturbance either insomnia or hypersomnia; restlessness and agitation, diminished energy, feelings of worthlessness and excessive guilt, decreased concentration, indecisiveness, and recurrent thoughts of death.

There are contradictions in the literature concerning the time frame for onset of postpartum depression and this varies from birth to twelve months postpartum. Hendrick, Altshuler, Strouse, and Grosser (2000) reported the onset of postpartum depression within the first four weeks after birth. Small, Brown, Lumley, and Astbury (1994) reported that almost 50% of depressed mothers began their depression after three months postpartum. The Agency for Healthcare Research identified major depression as more prevalent at two months and six months postpartum, whereas minor depression is more prevalent at three months (Gayne et al., 2005).

Various factors are known to correlate with postpartum depression. For example, high levels of prenatal depression are associated with high levels of postpartum depression (O'Hara & Swain, 1996). A lack of social support as a cause in postpartum depression is strongly suggested by several studies, (Beck, 1992, 1998b, 2001b; Gotlib, Whiffen, Wallace, & Mount, 1991; O'Hara & Swain, 1996).

Beck (2002) conducted a meta-synthesis of the predictors of postpartum depression and found that although all mothers experience hormonal changes, only ten to fifteen percent suffer postpartum depression. Studies that have examined pregnancy
hormone levels and postpartum depression have usually failed to find a relationship between hormone levels and postpartum depression (O’Hara & Swain, 1996).

The strongest predictors of postpartum depression in O’Hara and Swain’s (1996) meta-analysis were prenatal depression, prenatal anxiety, lack of social support, stressful life events and the mother’s history of psychopathology. The ten predictors with moderate effect were: prenatal depression or other history of depression, low self esteem, childcare stress, prenatal anxiety, life stress, low social support, and poor marital relationship, difficult infant temperament, and maternity blues. Beck (2001b) updated the list of predictors of postpartum depression and revealed three new predictors: “marital status, socioeconomic stress and unplanned pregnancy” (p. 275).

O’Hara & Swain (1996) found the major predictors to be a past history of psychopathology, psychiatric disturbance through pregnancy and a poor marital relationship. Predictors such as prenatal depression and lack of social support from the spouse, family, and others are strongly correlated with postpartum depression (PPD) and replicated in numerous studies (Beck, 1996; O’Hara, Schlechte, Lewis, & Wright, 1991). The correlation of lack of spousal support with PPD is undisputed and holds regardless of whether PPD is assessed by symptom levels from self-report instruments or clinical diagnosis (Breese McCoy, Beal, Miller Shipman, Payton, & Watson, 2006; Mauthner, 1999; Nicolson, 1999; O’Hara & Swain, 1996). Maternal age and birth sequence are other inconsistent predictors (Gurel & Gurel, 2000). Ethnicity and race are not typically significant predictors of postpartum depression (Yonkers, Ramin, Rush, & Carlos, 2001).

Mauthner (1999) found that women without social support, particularly the father’s support, are at significantly increased risk for PPD. Sixty percent of teenagers who become pregnant are living in poverty at the time of the birth and more than forty

The literature acknowledges the long term effects of postpartum depression born by women and their families. If left unidentified or untreated, postpartum depression can lead to serious consequences such as maternal suicide and disrupted maternal-child relationships. An example might be the mother’s inability to answer the baby’s cues which could negatively affect the baby’s cognitive development (Beck, 1996). There are numerous studies in the literature which have shown mothers reporting depressed mood to have more negative interaction styles with their infants; this has implications for the child’s emotional adjustment, language development and social responsiveness (Beck, 1996; Field, 1998; Murray, 1993).

Beck’s (1996) research confirmed long term effects from postpartum depression. Beck found that compared to non-depressed postpartum mothers, postpartum depressed mothers showed less affectionate exchange with their infants, and were more reserved with flatness of affect or conversely were anxious and meddling with their infants. Beck found that mothers with postpartum depression commonly have thoughts of harming their children, exhibit fewer positive emotions and more negative emotions toward them and are less emotionally available (Beck, 1996, 1998b). The infants of depressed mothers tended to be fussier and more dissatisfied and made less positive facial expressions and sounds compared to infants of non-depressed women (Beck, 2006; Breese McCoy et al., 2006).

Clemmens (2000) studied adolescent mothers with postpartum depression and found it affects the adolescent mother’s ability to make and sustain relationships, often
disconnecting her from caring contact with her infant and giving the nurturance needed by the infant to develop normally.

*Screening Tools to Detect Postpartum Depression*

Postpartum depressive symptoms in young mothers have been identified in studies; they were described and defined differently by the various researchers with a variety of screening instruments with different criteria and cut-off scores. Troutman and Cutrona (1990) reported higher rates of somatic symptoms among their sample, while Chen (1996) found higher levels of cognitive-affective symptoms. The Edinburgh Postnatal Depression Scale (EPDS) questionnaire is the most commonly used screening tool for postpartum depression (Appendix A). Cox, Holden, and Sagovsky (1987) and Yonkers et al. (2001) reported that an EPDS score of 13 indicates a probable case of postpartum depression, whereas a cut-off point of 10 or more would include possible cases. A score of 13 or more on the EPDS is highly sensitive for correctly identifying true depression cases (O'Hara & Swain, 1996). Beck and Gable (2000) believed that a variety of screening questionnaires have been used inappropriately to diagnose postpartum depression with no corroborating clinical diagnosis.

*Young Mothers and Postpartum Depression*

There is an assumption that adolescent or young adult depression will show itself in the same way as adult depression, but there is a possibility that the presentation of symptoms may be different and more difficult to recognize in adolescents and young adults rather than adults (Clemmens, 2000). When Deal and Holt (1998) looked at the existing data from the Maternal and Infant Health Survey they found that 48 percent of adolescent mothers had postpartum depression compared to twenty five percent of adult mothers. Logsdon, Birkimer, Simpson, and Looney (2005) confirmed this finding. In
"Depressive Symptoms, Stress, and Social Support" in pregnant and postpartum adolescents the authors found higher levels of a depressive illness in that population than in adult mothers (Barnet, Duggan, Wilson, & Repke, 1996). Birkeland (2005) found that 29% of their sample had a clinical level of depressive symptoms. Studies with adult mothers have shown that depressive symptoms in the postpartum period have negative effects on infant cognition and the mother–child interaction (Beck 1998b). The literature on PPD also points to how important family connections are and that social isolation can deepen a depression.

In Adolescent Mothers’ Depression After the Birth of Their Babies: Weathering the Storm, Clemmens (2000) explored the experiences of adolescent mothers following the birth of their babies. Clemmens addressed the largely unknown nature of adolescent mothers’ postpartum depression by eliciting the experiences from the adolescent mothers themselves. The study group consisted of twenty adolescent mothers, all less than nineteen years of age, who acknowledged depressed feelings beginning at the time of the birth of their baby, who had experienced a “normal” full term birth (seventeen of twenty delivered vaginally) and were English speaking. Clemmens conducted interviews in-depth and face-to-face. The participants were asked to respond to the statement: "Please describe your personal experience of feeling depressed after the birth of your baby" (p. 53) Clemmens (2000) identified the different ways adolescent mothers describe PPD. In her study she referred to adolescent participants who described PPD differently from adult mothers. Clemmens reported that adolescent girls with PPD may not be picked up by the screening instruments or medical tests commonly used to identify this phenomenon. She also found that the context of the participants’ lives was evident within
the descriptions of their depression. Other elements of her study are the importance of peers to the adolescent participants and the stress of being a mother and an adolescent.

Cross-Cultural Postpartum Depression

Several research groups have examined the cultural validity of the concept of postpartum depression in non-Western societies. The literature supports the concept that postpartum depression is a universal experience with common cross-cultural features (Oates et al., 2004). In Postnatal Depression Across Countries and Cultures: a Qualitative Study, Oates et al. looked for the prevalence of postpartum depression in fifteen different countries and found that it is not something confined to Western cultures. In rural Africa, Cox (1983) showed that ten percent of childbearing women were easily recognized as having postpartum depression compared to thirteen percent in Western cultures. Symptoms reported by Indian women diagnosed with postpartum depression included headaches, sleeping problems, worries, crying, giddiness, self-harm thoughts, tension, nervousness, a lack of interest in anything, fatigue, loss of appetite, irritability and sadness, body aches and feeling strange (Rodrigues, Patel, Jaswal, and de Souza, 2003) suggested that this evidence supports a universal clinical presentation of postpartum depression. PPD has been researched across cultures and is reported to be a serious mental health problem worldwide (Oates et al., 2004).

Aboriginal Women’s Health

Arnold and Bruce stated that “healthcare providers using the current literature as evidence see Aboriginal health constituted primarily within a biomedical framework of disease, treatment, and prevention” (Arnold & Bruce, 2005, p. 3). Aboriginal women’s healthcare providers who are serving Aboriginal communities have privileged the dominant Western worldview of health and healing (Arnold & Bruce, 2005). Western
medical practices have denied holistic practices so that Aboriginal women may be offered services for mental illness that do not fit within their Aboriginal worldview of health and illness (Arnold & Bruce, 2005).

Benoit, Caroll, and Eni (2006) examined Aboriginal midwifery in Canada and stated that in pre-contact Aboriginal communities, “the event of childbirth connected women to their foremothers and families to the whole communities (p. 12).” The Nuu chah nulth teachings revere the birth process (Benoit et al., 2006). From Benoit’s work we learn that Nuu chah nulth childbirth rituals connected women to each other, their mothers and extended families. Women had a role and responsibility to their families and to the community. The women learned this from their Elders. The birth stories that were told show the traditional way of sharing the details of birth and its connection to Mother earth. Men were given a place in the stories as supporters and providers (Benoit, 2006). Birth connected women to the earth. The baby was pulled from the earth. Interconnectedness within the natural universe was another component of traditional childbearing (Benoit, 2006).

According to Benoit (2006) the Nuu chah nulth Elders recalled that pregnancy and birth helped connect those involved -- the family, the midwife, and the extended family. Since colonization, birth rituals have been usurped by modern medicine. Birth traditions, like so many vital traditions, have been lost; instead, birth has become another biomedical institution of itself. Benoit suggested that by supporting Aboriginal women in childbearing the colonizers have taken away another aspect of Aboriginal self-governance. Aboriginal women became part of the “at-risk” discourse in obstetrics and this again reduced the capacity of women to experience childbirth as part of a community, in company with family and family tradition (Benoit 2006).
Socioeconomic and political factors affect health (Provincial Health Officer, British Columbia, 1996). Browne, Smye, and Varcoe (2005) stated that the health and mental-health problems of Aboriginal people are a direct consequence of colonization. Brant (1994) identified hardship caused by poverty, despondency, inferior housing, and political separation as the derivative causes of many health problems prevalent within Aboriginal communities. The dominant mental health problems for Aboriginal people are social in nature, rooted in a history of oppression and the current social conditions (Browne et al., 2005).

The statistics on the health of Aboriginal peoples in Canada reflect that Canadian Aboriginal women have a lifespan ten-to-twelve years shorter than non-Native Canadian women (Health Canada, 1999). A Health Canada survey reveals that the birth rate for Aboriginal women was twice the overall Canadian female population (Statistics Canada, 2006). Aboriginal mothers were younger: nine percent under eighteen years of age compared to one percent in the non-Aboriginal community. The 1995 Health Canada statistics show that 55 percent of Aboriginal mothers are between 18-25 years of age as opposed to 28 percent in the non-Aboriginal community (Health Canada, 1996). Barksdale et al. (2001) found that Aboriginal women’s definition of their health status is different than non-Aboriginal women. Within the Aboriginal health literature (Dion-Stout & Stout, 2001) numerous studies have highlighted the difficulties that Aboriginal women face in gaining access to health services. When they do connect they often contend with racism and culturally unsuitable or difficult to get to health services (Health Canada, 2003).

The Aboriginal Women’s Health Research Synthesis Project looked at the prevalence of postpartum depression in Aboriginal women and found a dearth of
literature available that even mentions this issue (Dion-Stout & Stout, 2001). A factor that may influence is that the prevalence of psychiatric disorders is based on service utilization records, but since many Aboriginal people never come for treatment. Service utilization is only a lower estimate of the true prevalence of distress in the community (Dion-Stout & Stout, 2001).

The long-term effects of poverty and marginalization are reflected in the lives of young Aboriginal mothers. In Healthy Living and Aboriginal Women, Dion-Stout (2005) found that there was a high incidence of depression in Aboriginal women. It is possible that living off-reserve Aboriginal people are experiencing depression at a rate of 1.5 times higher than the general population (Kirby & Keon, 2004) and that young Aboriginal populations have a high prevalence of mental health problems due to the socially disenfranchised context they are living in. The rate of suicide among Aboriginal youth in Canada is five-to-six times higher compared to non-Aboriginal youth (Health Canada, 2006).

Qualitative Research on Postpartum Depression

Prior to a key qualitative study by Beck (1992), PPD was viewed as a bio-medical problem most of the research on PPD had been quantitative. Beck identified three new themes connected to the phenomenon of PPD: contemplating death, loss of interest, and guilt. More recent qualitative work that focused on the subjective experience of PPD (Clemmens, 2000; Mauthner, 1999; Nicolson, 1999; Sichel & Driscoll, 1999) substantiates the themes identified in “The Lived Experience of Postpartum Depression” (Beck, 1992). Before this qualitative work women’s subjective experiences of postpartum depression had not been documented. For this study I used elements of an ethnographic
approach to obtain young Aboriginal mothers’ accounts of PPD in order to add to the literature. The methodology used for this study is discussed in the following chapter.
CHAPTER THREE:
TACTICS OF INQUIRY

The purpose of the study was to explore the postpartum experiences of young Aboriginal mothers. In this chapter I describe and discuss the method and procedures used in the study.

Ethnography

This study is guided by ethnographic research approaches and draws on an ethnographic method. It draws on the aims and procedures of ethnography. Ethnography is a qualitative research method used in social science research to seek emic understandings of a shared culture (Creswell, 1998). An ethnography allows a way of thinking about and studying social reality to make sense of everyday life (Hammersley & Atkinson, 1983). Ethnographic research takes the researcher closer to the social reality of participants’ lives by examining their taken for granted day to day world. Ethnography is the work of describing a culture (Spradley, 1980). This method focuses on a natural point of view. The goal of this methodology is to create data that is genuine and closely identifiable with participants’ everyday way of being. As much as possible, the researcher interprets participants’ “world in the same way they do” (p. 7). Participant observation and open-ended interviewing are the main research strategies that I used in this study.

“Ethnography is the work of describing a culture” (Spradley, 1980). Culture represents a way of viewing the world by categorizing, encoding, and otherwise describing the world of a particular culture sharing group (Spradley, 1980). It includes suppositions about the nature of reality as well as explicit details about that reality (Spradley, 1980). This methodology encourages the ethnographer to see the culture from
a new vantage point. In this study, I attempted to capture the cultural meanings that participants' gave to their everyday lives. The goal of this ethnographic study was not to produce an unequivocal truth about a culture, but to add insight into the lived experiences of the culture sharing group and the lived experiences of being young Aboriginal mothers.

Research Ethics

Prior to the data collection, I obtained ethics approval for the study from the University of Victoria's Ethics Committee and the Nuu chah nulth Ethics Committee. It is no longer legitimate to conduct research with an Indigenous group without demonstrating appropriate respect for their values and receiving approval for the research. The document Protocols and Principles for Conducting Research in an Indigenous Context (University of Victoria, 2003) guided this process, which is designed to facilitate the ethical conduct of research with Aboriginal people. In the past Aboriginal people have been researched without due respect, and the university's guidelines are in place to scrutinize the procedures involved in researching Aboriginal peoples. The ethical standards are higher and uphold the principles of "protection, partnership and participation" (p. 3). I used this document to guide my research ethics for this study.

Furthermore, to promote ethical and culturally competent research involving Aboriginal people, the Nuu chah nulth had their own research ethics guidelines. I worked closely with the Nuu chah nulth Research Ethics Committee to help ensure that I adhered to their guidelines in order to obtain permission to conduct the study. In a letter that accompanied my application to the Nuu chah nulth Ethics Committee, I asked for permission to pursue this research project in their territory. The letter of request to conduct research with the Nuu chah nulth people is included as Appendix B.
Informed Consent

The University of Victoria guidelines for conducting research with Indigenous peoples (University of Victoria, 2003) help to ensure that the rights, interests, and sensitivities of the participants are protected. I understood from the guidelines that my research had to convey my aims as the researcher, and I outlined them in the consent material and in verbal explanations to the participants. I assured them that I would maintain their anonymity according to the ethics process, but acknowledged that it would be difficult to do so if the community was aware of their participation. However, I informed the participants that my protocol would safeguard their confidentiality. I used pseudonyms throughout the research process and omitted or changed any identifying details.

I attached an information sheet to the consent form and encouraged prospective participants to ask questions and clarify their understanding about the study and about their involvement in the research process (Appendix C). The information letter reinforced the details in the consent form and explained how I would conduct the study as well as the issues related to confidentiality. After the potential participants had read the consent forms and before they signed, I informed them of the measures that I would take to protect the anonymity of their interview data. I gave each participant a copy for her records.

Mason (2002) reminds researchers that “getting informed consent is actually quite a complex and difficult business” (p. 80). Madison (2005) described the consent process as “dynamic and continuous. . . . You will want to consider how you can be sure what you have gained is actually informed consent” (p. 114). I chose to ask the participants to reconsider their consent and to initial and date the consent forms each time we met. It
was important that the research process be “open, direct and transparent” (University of Victoria, 2003, p. 5), which required that the participants understand that the research information they supply would belong to them and that they had an “absolute right to exercise control” (p. 5) over the information they volunteered. The University of Victoria’s guidelines suggest that “fair return should be given for participants’ help and services” (p. 6). I compensated the participants to recognize their contribution to my research and to honor their time for the study. I considered the amount of $25 be fair and not coercive.

Cultural Safety

Cultural safety is a way of shifting the focus of examination away from cultural characteristics or cultural differences as the source of the problem and instead focusing attention on power imbalances, on individual and institutional forms of discrimination, and how these play out in health-care practices (Browne, A., & Varcoe, C. (2006). Cultural safety insists that inequities are recognized in healthcare and the history of economic, social and political subordination locates the health and social conditions of Aboriginal people. Cultural safety came forward as a way that nurses and researchers could begin to take action to put right some of the inequities of colonial practice that still linger in our practice as nurses today.

Healthcare delivery still manifests the colonial tradition which affects the Aboriginal population by patronization, victim blaming, and authoritative use of western European medicalization. Nurses are learning to reflect on their values and beliefs in order to interact more positively with the values and beliefs of ‘others’ (Smye, 2006). This has been seen in the interactions between Aboriginal women and the health service providers which mirrored their relationship in the broader sociopolitical and historic
context with a power-over relationship between the provider and the receiver of healthcare services.

The recognition and effort to change practices embedded in institutional ways is an important strategy to change the persistent disparities in health and healthcare. Cultural safety is a way of incorporating and redressing the inequalities that have traditionally affected the health of Aboriginal people. Aboriginal women carry a "burden of history" (Browne, 2005, p. 22). This burden reinforces unequal power relationships that were established by colonial politics but continue overtime. This affects their interaction with healthcare providers who continue to presume that Aboriginal mothers have certain essential deficits in their ability to be healthy and are passive participants in health care encounters. Aboriginal women often find that their views are dismissed which leaves them feeling stigmatized by the system.

Arnold and Bruce (2005) urged the pursuit of understanding of cultural safety and the recognition of the unequal power relations between healthcare providers and clients based on colonial history (p. 3). The colonial practices have long lasting affects. The participants of this study have continuing discrimination in their lives which affect how they choose to receive healthcare and how healthcare is made available for them in everyday practices and policies.

It seems that healthcare delivery and healthcare research have objectified Aboriginal people and stereotypes have been accepted as culturally authentic representations. Health care services have become institutionalized to fit the stereotype invented by the colonial gaze (Browne & Varcoe, 2006, p. 161). It is therefore important that I scrutinize my own assumptions about the participants and recognize the shadows of context and assumptions that affect the research. It is important to recognize the shift
from cultural sensitivity in practice and extending this to cultural safety. Ensuring cultural safety for the participants in this study requires inquiring about the social, political, and economic contexts that affect their lives. An example that I can attribute to culture is the silence that occurred when I asked the participants whether they had any questions before they signed the study consent form. Without an understanding of the context of colonialism I could have interpreted the silence as reinforcing a negative stereotype of passivity and conformity instead of a culturally specific way of conveying their respect.

Theoretical Framework

Hammersley and Atkinson (1983) commented on the power of a paradigm and explained how it shapes our view of our subject in unconscious ways. Paradigms or perspectives towards the data influence what we decide to attend to and not attend to and what is obscured (Guba & Lincoln 1994). A paradigm is defined as a “basic belief system to guide the investigator, not only in choices of method but in ontologically and epistemologically fundamental ways” (Guba & Lincoln, 1994, p. 105).

I used a constructivist theoretical approach for this study (Hammersley & Atkinson, 1983). Guba and Lincoln (1994) describe constructivism by posing philosophical questions about the basic assumptions of the theoretical approach:

What is the nature of reality? A constructivist believes that realities are multiple, intangible mental constructions (Appleton, 1997). What is the nature of relationship between the researcher and what can be known? A constructivist researcher takes a subjectivist and transactional approach to examine phenomena. The interaction is between the researcher and the participant who create the findings together. It is important to recognize that people may hold similar views about the nature of social
reality within and across cultural groups but to accept that “beliefs have no timeless validity; they are in the moment” (Appleton, 1997 p.15).

The constructivist paradigm recognizes that the situation and situatedness of people vary from time to time (Guba & Lincoln, 1994). Within the constructivism paradigm there is no such thing as an objective knowledge of realities other than what the knower knows. The study participants are therefore influenced by the “social, cultural, and historical context” of their lives (Guba & Lincoln, 2005, p. 24) . Constructivism adopts a relativist ontology (Hammersley & Atkinson, 1983)—the recognition that the social environment determines and is embedded in individuals’ values and practices. Appleton (1997) discusses that one challenge of constructivism is to reconcile the understanding of relativism with the desire to apply findings to other similar groups and this can represent a paradox for qualitative investigators. There are difficulties when the views that emerge cannot be funneled into an explanatory theory. Appleton (1997) advises that the framework for constructivist investigation in nursing should be stimulated through the “experiences, interest and knowledge of the investigator” when the investigator can use intuition to guide the process (p.18).

This theoretical framework offered me as the researcher a way to co-create meaning with the participants. With the information derived from the study data, the constructivist aims to “restructure understandings of the social world of the participants” (Denzin & Lincoln, 2005, p. 24). This approach helps the researcher to acknowledge “the possibility of multiple realities, ways of knowing, and stories rather than accepting only universalizing narratives” (O’Riley, 2003, p. 43). It was important to attend to the way the individual participants were influenced from a feminist perspective
Feminist Perspective

The nature of qualitative research encourages the researcher to bring a subjective view to the research. I acknowledge that I am biographically situated, "simultaneously guiding and constraining the work" (Denzin & Lincoln, 2005, p. 22). It was important I contemplate how I was situated in a place of privilege as a white middleclass professional woman accustomed to the power over position that often comes with the position of a registered nurse.

I integrated a feminist perspective into the study to position the women’s voices at the forefront and to give the women authority. Wilkinson (1986; as cited in Webb, 1993) commented that feminist research should give precedence to developing theory that is firmly situated in women’s experience. I attended to what the participants said as they told their stories, which enabled them to “become active agents, the creators of the worlds they inhabit and the interpreters of their own experiences” (Marecek, Fine, & Kidder, 2001, p. 34).

The research process positioned me as a nurse researcher with questions to ask of the participants. I acknowledged my position created a power-dynamic in the researcher-participant relationship. However I reflected on how I was positioned as a nurse, holding nursing knowledge of the phenomenon of PPD and attempted to put this aside as I asked the participants to teach me about their own experiences. I chose to be an inquirer respecting the experiences of the participants.

Initial Contact

I made my initial contact by distributing information letters (Appendix A), displaying an advertising poster (Appendix D) in a local Native Friendship Center, and giving potential participants a letter of information on how to contact me (Appendix C). I
also advertised in the local Aboriginal newspaper. The public health nurse also
introduced me to potential participants who were attending a clinic at the health centre.

Entering the Field

The Vancouver Island community within which I accessed my participants had
been the focus of the media because of a case of child neglect in the Aboriginal
community that involved the death of a First Nations toddler under the care of the
Ministry of Child and Family Development and First Nations social workers in the
community. A criminal investigation was still in progress during my contact period.
Widespread publicity resulted, and the Ministry of Child and Family Development
department, social workers, and family members faced recriminations. The media
attention meant that most people in the community would have been aware of the story. I
believe that this recent tragedy curtailed my initial attempts to enter the field.

My impression was that a nurse researcher who was asking questions about
mothering was intimidating and that mothers would be reluctant to become involved.
Only one mother came forward after two community presentations. The first presentation
was to the staff at a drop in group that served mostly Aboriginal mothers. The group
director was protective of the clients’ privacy and their possible exploitation in a research
study. The study criteria were discussed. I was given permission to pin up the information
pamphlet but I understood there would be no active recruiting by the staff. The second
presentation a month later was to public health nurses who were very interested and said
they could help with recruitment by telling their clients about the study. Eventually,
during the next month an academic colleague who is a member of the Nuu chah nulth
First Nation opened the gate for me to access participants. Although this was not my
initial recruitment strategy, it facilitated my introduction to young Aboriginal mothers.
My colleague, a graduate student in social work, was well known in the community and informed friends and family about the research.

**Identifying the Participants**

A potential participant telephoned me after having seen a poster advertising the study. She called me collect, but because she was moving and her life was stressful, we did not have a chance to meet. The social worker mentioned above referred a second potential participant. The social worker had phoned an acquaintance with a daughter who fitted the study criteria. The daughter contacted me by phone. After the initial introduction was facilitated by the social worker or gate keeper I met with my first interview participant at a local restaurant. Through the first participant who referred a friend to me and with whom I met, I was serendipitously introduced to more participants. When the potential participants called me, I was able to give them more information about the study which they in turn circulated to friends. I sensed that the personal recommendations, with the added formality of a study consent form that acknowledged that the Nuu chah nulth Tribal Health Ethics Committee, reassured the participants. I assured them that I would keep their information confidential and that they were free to withdraw from the study at any time.

**Participant Group**

I anticipated gaining access to six young Aboriginal mothers aged between 16 and 24 with babies between birth and six months of age. I interviewed six women, but two interviews were ineligible because the participants moved away after the initial meeting, and I was unable to contact them again. One participant interview was of poor quality because of background noise, and that participant did not return my calls. In the end I interviewed three mothers twice each for approximately an hour each time. The three
young mothers who were included in the study were all 21 years old. When I first interviewed them, their babies had all been born within the previous eight months. Two of the young women also had sons, each six years old. The six-year-old son of one mother lived close by, whereas the other mother had been separated from her child for several years. The participants had rural upbringings in different First Nations communities. Each mother had initiated breast feeding, and two were still breastfeeding at six months postpartum.

Influence of the Researcher’s Role

Ethnographers do not merely make observations; they also participate. For example, by being invited into a participant’s home, the researcher has already impacted the situation and the interview in many possible ways. Participation, a normal element of ethnographic interviewing, allowed me to experience activities directly, to get a ‘feel’ for events as an observer.

The ethnographic interviewer sets the stage for the interview and thereby influences the data by the choice of questions and how they attend to developing the interview. Spradley (1980) suggested that ethnographers’ understandings are constantly pressed from a point of unknowing that they labor to fill by posing questions to their informants, who are the holders of insider knowledge. The interviewer is integral in the development of the shared knowledge that develops during the interview.

It was challenging to maintain a position that upheld the ethical bounds of my research and to guard against the interviews becoming a “therapeutic encounter rather than a co-creation of knowledge” (Kvale, 1996, p. 156). Within the research work the participants wanted to be friends, in addition to sharing their emotional lives and their stories. This is part of the ethnographic interview method. The challenge was to stay
distinct from the participant and as a researcher I was constantly aware of the necessity to
"position [myself] as self-conscientious, critical and participatory analysts engaged with
but still distinct from [my] informants" (Fine, 1992 p. 220).

I was aware of the power and privilege that I carried as a researcher and wanted to
acknowledge this and prevent it from becoming a disadvantage in the interview setting. I
was also aware of my assumptions and biases and how they might affect the interviews.
As an example, I acknowledge my use of leading questions asked in the interviews; "And
then you were thinking about the future?" I was expressing interest in how they felt about
the future. "Were you imagining what it was going to be like living in town with the
baby? I'm just wondering if you felt like running home, and maybe you just thought you
were going to stay on and do it, live there?" My question redirected this part of the
interview towards my assumption that moving from one community to another is
difficult. Comments about a boyfriend or a desire to be out in the party scene came up in
the interviews and led me to assume a transitory nature to the relationships they had with
their babies' fathers, maybe because of their age and transition between communities. I
realized on reflection that this was not necessarily the case, but rather was an assumption
on my part. I struggled to keep my own opinions from overshadowing the conversations.

Data Collection

The Ethnographic Interview

Spradley (1980) recommended interviewing in a location familiar to the informant
as a way to build rapport. I made nine trips to the community. Two were disappointing
when arranged meetings fell through but seven were productive, for example when I
arrived for a morning interview and met another participant later in the afternoon.
Ethnographic fieldwork took me to where the participants were. We talked at the local
Dairy Queen and spent time in the Wal-Mart car park, on a park bench, and at a Subway food outlet. I walked across town with one participant, at her invitation, to a meeting she had with a friend. The time that I spent in the community helped to build rapport and “season me” to the participants’ cultural surroundings, and to understand what they did day to day. The young women were unaccustomed to interviews. However, being in their own environment appeared to decrease the anxiety they may have had about being interviewed. I arranged to interview each participant for approximately one hour. I interviewed each participant twice. Each interview was audiotaped and transcribed for analysis.

Introductions and informal discussion preceded the necessary formality of signing the consent form. I asked the participants to sign two copies, one of which they kept; I also asked them to fill in a demographic history form (Appendix E) which included their home town and information about their families and their aspirations.

According to Spradley (1980) a principle of ethnographic research is that the researcher must clearly convey certain elements of the research process to the participants. I explicitly described the purpose of the interview to each informant on the phone before we met and again during our first meeting. Prior to our meeting, I informed the participants that I would audiotape their interviews and take notes. We discussed their role of being my “teacher” (Spradley, 1980) in the interview process.

I want to understand the world from your point of view. I want to know what you know in the way you know it. I want to understand the meaning of your experience, to walk in your shoes, to feel things as you feel them, to explain things as you explain them. Will you become my teacher and help me understand? (Spradley p. 34)
Some of the interviews demonstrated my role as “learner.” When the participants told me about their home life and family dynamics, such as their early life with an alcoholic parent I learned from these comments. This altered my understanding and expanded my thinking. Spradley (1980) described using an open approach to learning from the participant. An example in this study was a comment when I asked about being lonely in the postpartum period. Marla wanted me to understand, to teach me, that under her circumstances in her new role as a mother she chose to pretend that she was happy. She wanted me to understand her strategy. I chose the format of a dialogue—a two-way guided conservation—with the purpose of hearing about the participants’ postpartum experiences, a move from a one way question and answer interview to construction of new knowledge between people (Kvale, 1996). I asked a participant if she had felt depressed after she had had her baby. She initially said simply, “Ummm, no,” and I let that answer go; then, considering this statement, I asked her, “So the days, the weeks, the months went by?” She then talked in depth about a depressive period that she recalled.

Spradley (1980) observed that “an informal ethnographic interview occurs whenever you ask someone a question during the course of participant observation” (p. 123). The interviews within this study contained semi structured questions (Appendix F). Questions help to organize meaning and illustrate how the participants view their world (Spradley, 1980). The initial interview questions often generated a follow-up question such as “You just said you were on your own a lot. How did that feel for you?”

I used contrast questions (Spradley, 1980) by asking the participants to elaborate on the inconsistencies or contradictions they mentioned in order to see the existing differences and to assist me to understand them. The contrast questions are generated
from within the same category as seen by the informant. An example of this was when I asked them to expand on what they viewed as the support they received from their partners. They described many things from the support-domain: changing a diaper, getting food and doing washing and also that their partner chose to stay at home with them. I then asked the participants to consider their answers to this question and I helped them to “sort” them by asking what support worked best for them. The questions sometimes led the participant to reflect on and to change her original stance. Marla told me that she had not suffered with depression, and then within minutes she commented, “I can’t even believe half the things I thought in my head. At one point I even told someone, ‘I don’t even want to live any more,’ and I didn’t say ‘Just kidding or anything.’” This is another example of the participant’s search for a way to describe her feelings more thoroughly which allowed the interview to build and develop. For a summary of the interview questions, see Appendix F.

*Ethnographic Analysis*

The constructivist view, located in a constructivist paradigm, has allowed me to generate understanding of meaning in participants’ lives and broadened the ethnographic analysis as described by Spradley (1980). For this analysis I read each transcript for the story that each participant told in the interview; this allowed me to see the overall form of the interview and familiarize myself with it before I examined the data for domains (Spradley, 1979).

Spradley (1980) explained that the researcher must expect the participants to construct meaning of their world by organizing their knowledge of life’s happenings and objects into characteristic replications or patterns. Categorizing these things helps the participants to simplify their experience (Spradley, 1979). Informants organize their
knowledge of their world by categorizing objects, time, people, and places in their world (Spradley, 1979). Domains or topic areas that participants referred to repeatedly were noted and became established as units relevant to my research question (Spradley, 1979). An example might be the way participants categorized the people in their lives. People they know fall into one of several groups: family, friends, elders, healthcare professionals or professional people in authority. The terms and phrases that the interviewees used provided the initial units or domains (Wolcott, 1990) that allowed me to analyze their cultural world and gain insights into the organization of their experiences during the postpartum period. My examination of the specific topics in the data revealed patterns (Spradley, 1979) that occurred and reoccurred in participant’s lives which in turn gave more insight into the participants’ culture.

The next step was to condense the transcripts and draw out the words, phrases, and points of speech that seemed important and were relevant to the topic. Analysis of the transcripts and journal notes was based on the assumption that “patterns will occur in the data” (Spradley, 1980, p. 99) and that the interview could be organized into categories or themes (Spradley, 1980). Questions that I asked of the data included the following: Are there patterns? What stands out as surprising, contradictory or puzzling? What does intuition or common sense knowledge tell? Are there inconsistencies or contradictions within the data? (Hammersley & Atkinson, 1983). This was exemplified by the way the participants arranged their answers. For example, when asked Jeanie was asked about the support she received she listed “bringing home food” “putting out the garbage” and Jay “choosing to stay home with her.” Two answers were similar the third one was different. This sort of support was then qualified with more description. The contrast was further
understood when it was qualified again. Their partner staying at home but choosing to have their friends there was not viewed as being supportive.

The process of data analysis began with my use of three methods to isolate thematic statements in the transcripts. I questioned what the sentence revealed about the experiences of the participants and attempted to label each sentence or cluster of sentences with a keyword. Keywords are usually direct quotations from the transcripts. This was a judgment call on my part. I used different colored highlighters to code keywords (Spradley, 1980). I then read the transcribed interviews again, looking for patterns. I used different strategies for looking at the data, generating meaning from repetition, contrast and comparison, variables and their relationships, metaphor, simile, emphasis, exaggeration (Miles & Huberman, 1994).

The next step was to move from keywords and concepts to themes and subthemes, which required that I review all of the data again to look for connections and keywords and develop them into concepts. I moved slowly from keywords to concepts to subthemes and, eventually, to themes I then created a rough table of significant words and phrases, keywords, and concepts, which I developed into several subthemes.

Field Notes

Field notes are also part of the data (Spradley, 1980). Each interview was accompanied by my intermittent research journal entries. I recorded field notes during the interview, but more often I audio taped reflective notes, usually as I drove away from the interview. When I arrived at a participant’s house on the reserve, I made many observations. I wrote a few key words, but I was engaged in the interview and found it impossible to make notes at that time. Instead, as I drove away I recorded all of my observations on audiotape during the three-hour drive home. Later I transcribed them,
and they became part of the data. I also added them to the transcript soon after the interview.

Quality of the Study

Evaluation criteria help to capture the worth of qualitative work. Guba and Lincoln (2005) developed criteria for judging the processes and outcomes of naturalistic inquiry that they called “authenticity criteria” (p. 209) to ensure fairness and balance. The criteria used to judge qualitative work are categorized in two primary areas relevant to all qualitative research: credibility and authenticity (Guba & Lincoln, 2005).

Credibility

Initially credibility for this research study was established by identifying my affiliation with the University of Victoria and following the University guidelines for ethical practice when conducting research on human research subjects. The goal of ethnographic research is to understand the cultural patterns and meaning in the domains identified in the data (Spradley, 1980). To optimize the goal of understanding the truth or credibility of the data, each informant was asked to confirm their contribution as “valid and trustworthy” by confirming that they recognized the words and themes presented (Denzin & Lincoln, 1994, p. 207). Denzin and Lincoln maintained that a study is valid when it is “sufficiently grounded, triangulated, based on naturalistic indicators, carefully fitted to theory, comprehensive in scope, credible in terms of member checks, logical and truthful in terms of its reflection of the phenomenon in question” (p. 579).

Guba and Lincoln (1985) regarded member checks as “the single most critical technique for establishing credibility” (p. 239). This method involves taking data back to the participants so they can give their view of its credibility and accuracy. After the first interview I offered to give each participant a copy of the transcript which they declined. I
asked my participants to review my findings with me by way of a conversation and this was conducted between the interviews. They appeared not to want to engage with their words on paper so instead we talked about some of the points raised in the first interview. Interestingly there were examples of the participants forgetting they had said something. For example, a participant didn’t remember referring to an argument with her boyfriend and when I recalled it from the transcripts she hesitated and at first she was confused but she did remember and it was included in the data.

Qualitative research is a reflexive process (Cutcliffe, 2003). This happens by sharing insights and experience throughout the research process in order to make it more transparent to the reader, particularly where the reflexivity influences decision making. Reflexivity refers to the researcher being part of the research, not separate from the research (Cutcliffe, 2003). The reflexive process enhances the researcher’s immersion in the data which is also critical (Morrow, 2005). Reflexivity is used to augment the findings to show a sense of balance between the participants’ words and my thoughtful interpretations.

My aim was to make the research processes transparent to allow the reader to determine the quality of the research study. This was accomplished in two stages: by use of reflexive journaling and notes taken during participant observation, with the addition of audiotapes which chronicled my feelings as I left the interviews. The audio tapes were then transcribed and incorporated into the data. Adequately integrating the data sources builds a foundation to support the participants’ “telling the truth” (Morrow, 2005, p. 256) as they know it.
Authenticity

The researcher must attempt to remain true to the phenomenon under study, demonstrating sensitivity to the subtle differences in the voices of the participants and attention to influences of their own perspectives (Whittemore, Chase, & Mandle, 2001). Authenticity here relates to the confidence that the study results will reflect the meaning and lived experience of the participants. The authenticity of the study is established by remaining open to new ways of thinking about PPD and to the participants’ voices in the transcripts. In order to accomplish a truthful reflection of their voices and the meaning within their lives I focused on including many direct quotes from the transcripts. The following chapter will present the findings of the data and present the themes that related to the young mothers experiences.
CHAPTER FOUR:

FINDINGS

Participants

This chapter is divided into two sections: an introduction to the participants and a discussion of the themes common to their experiences. The first section is organized to introduce each participant and interview setting, followed by a brief description of their early postpartum experiences. The second section is a detailed exploration of the themes. I have assigned a pseudonym to each participant.

Marla

Marla heard about my study from a mutual acquaintance and returned a call from me. We chatted briefly, and I told her I was interested in learning about her personal experiences of the postpartum period for my master's research. She seemed to like the idea of broadening both of our perspectives on her life during the postpartum months. She also told me briefly about a post-high school program in which she had been enrolled. She was interested in training for a career in child and youth care, which was now on hold. We agreed to meet at a local Subway food outlet, which was an easy landmark—a busy place in the centre of this mid-sized town on the west coast of Canada.

I decided not to record our first brief meeting. The first introduction allowed Marla to get to know me and for me to answer her questions before participating in the study. Her father had taken her to the meeting in his truck. As Marla and I sat and arranged ourselves at the table with the baby buggy and gear, I noticed that she was organized. Baby toys dangled from the stroller. Her baby gear was clean, and she had a pack sack with milk. Her daughter was eight months old and seemed placid, dozing in her
stroller. The restaurant was busy, but we talked easily in the hubbub of the afternoon. Many of the people in the restaurant were Aboriginal.

Marla told me that she was 21 years old and had been raised in an Aboriginal community in northern British Columbia. Her parents had separated when she was 10, and she continued to live with her mother through most of her childhood.

A week later I met with Marla in a quiet restaurant and conducted the interview. The interview was audio-taped. We laughed about the audio-recorder on the table between us and both ignored it as we talked. Our conversation proceeded with her reflections on her pregnancy and the months after the birth of her daughter, Elly. We established an easy rapport, which allowed the conversation to deepen; our talk switched between her lived experience of the past and her life now.

Marla’s mother had been a “heavy” alcoholic who had stopped drinking when Marla was in her late teens. I did not ask about those years in depth, but they seem to have been a difficult time. Her younger sister was pregnant the year before Marla graduated from high school. After graduation, with financial support from her band, Marla moved to another town to study. When she discovered that she was pregnant, she said that she had cried with mixed emotions. During the seventh month of her pregnancy Marla moved to Vancouver Island. She accounted for the move:

It was really hard to for me to decide though because people I imagined being there when I was pregnant was my mom and my sister. My mom and my sister both experienced it . . . . Mom is the one who comforts me; she always manages to help me somehow. And Elly’s dad [Jay], he really wanted me to come to the Island, and he said he would take care of me, but that didn’t happen.

Marla moved into a house with her boyfriend, Jay. They had a room in the basement of his parents’ home. Towards the end of the pregnancy she became isolated
and spent more and more time alone there. The turbulence of the postpartum period began for Marla while she was still in the hospital recovering from a caesarean section. She found herself crying in the first days postpartum, and Jay was not very often there:

I remember on the third day or something, I just felt like I had made a mistake by having a kid with Jay, and what am I doing? Why did I have a kid right now? A couple of nurses came in there, and they asked me if I was okay. They could hear me crying in the hospital, and they were like, “What’s wrong?” And I’m like, “Because I asked Elly’s dad to stay with me because I was lonely here, and he said yeah. And then he got a call. but he wouldn’t answer in front of me, so in my mind I was just assuming like it was another girl or something or whatever.” It’s like, “I did this whole pregnancy, you know.” I felt like, if he doesn’t come back, then don’t come back at all.

A week postpartum Marla returned to Jay’s parents’ home with the baby, but she found herself cloistered in the basement away from the family. During that period she “pretended to be happy.” It was evident many times in the interviews that she wanted to play the part of the happy new mother, and she told me that she tried hard not to wallow in self-pity:

Jay chose to neglect—not neglect, but avoid our daughter. In his mind he was helping me. He wasn’t bonding with his baby. It got frustrating because I just thought, This isn’t your step kid. I remember I just felt like I had made a mistake by having a kid. . . . I did this my whole pregnancy. . . . He says he’ll do something, and he never does.

Marla was frustrated with the lack of support. His protestations made her angry. Marla’s description of that situation and her mixed feelings are significant as an expression of her need for support, but having received something less. Marla began to make new meaning of her relationship with Jay. Her conversation illustrates the experience of loneliness that she was living through; loneliness that was common to all of the participants in this study.
Jeanie

Jeanie heard about the study through a friend and her boyfriend’s mother. She returned my call and agreed to see me the next day. I felt lucky to have the introduction and organized some snacks and my paperwork before I left to visit her. The next day I arrived at Jeanie’s house; it was a grey, wet, west-coast morning. The social housing unit in which Jeanie lived was in rough shape. It was a small townhouse hugged on both sides by identical façades, and I could see both the newness and the decrepitude of the structure.

I knew virtually nothing about Jeanie other than that she was 21 years of age and had a four-month-old baby. She met me at the door. She had washed her hair, put on makeup, and seemed ready for a visitor. I was struck by her serenity and her plain, fresh complexion and countenance. My initial impression of the living space was of disorder, but nothing was in extreme disarray. It looked as though Jeanie and her baby had just moved in and started to get organized and unpacked. Another young Aboriginal mom, her friend Mel, was also there.

Mel stood by and soon joined in the preliminary introductions. Because she was from Jeanie’s coastal community, I considered Mel, a young mom who met the criteria to participate in the study, as a possible participant. I tried to arrange us around the kitchen table, and we moved items so that we could sit. Jeanie and Mel chattered and laughed. Mel was also interested in the study, and because she was a member of the band from whom I had permission to conduct the research study, I offered her a consent form too. Jeanie and Mel pored over every word. Although they seemed to have read the form very slowly, they acknowledged that they understood the wording. As a precaution I reviewed the form with them, using language that they would easily understand, and explained that
their band had an ethics committee that was involved in the research process. I wanted them to know that this committee had reviewed and approved this study. Mel said that she would consider it for the future. However, she planned to leave town in the next few days, and she did not participate. She left the room but popped in a couple of times; otherwise, Jeanie and I were alone.

Prior to starting the interview, I arranged the tape machine on the table. Our interview began as Jeanie told me that she had grown up with Mel and that they had spent their childhood days in a small, isolated, west-coast Aboriginal community. As a teenager, she had come to town, and she told me about some of her life experiences:

Having my kid at fifteen years old was really hard, ... but I was still in school too. It was really hard sometimes, getting up really early, have to have a shower, get my kid ready. Sometimes his dad would come and pick him up. It was really hard though. My baby sister used to drop him off at daycare when I had to go to school really early. She was only fourteen years old, helping me a lot. She’s having her own baby too.

This brought us to this pregnancy, and Jeanie described her daughter’s birth and her sense of happiness and relief in the first two months postpartum. However, things changed: Jeanie became tired and spent more time alone:

Then I got tired and drained out, and then thoughts went around and around. He can leave whenever he wants, go back to his friends. I have to keep telling him to stay around. His friends want to come here to the new place just to hang out. That’s okay till they [the neighbors] get angry.

Jeanie referred to her sister, who lived in Ontario, as her main support person:

“I’d talk to my sister, and she’d cheer me up. Try to be sad and she’ll just tell me something else. When I’m lonely I call her. It’s kind of hard being lonely with a baby.”

Before I met Jeanie for our second interview, she warned me on the phone that she had a bruise on her face: “I got a trouble with a bruise.” It seemed to “just be,” she
said, because “things had blown up that last weekend.” I said, “Thanks for telling me, and I’ll see you tomorrow.” I was reminded of the narrow line that I trod. I had promised her confidentiality while at the same time knowing that I had a responsibility to report her situation if I thought her children could be at risk. I was aware that I might pose a threat to her. There was a clear danger signal from her Ministry of Child and Family Development social worker that she might lose a child if she could not be protected from an abusive partner. After consulting with my research supervisor and a committee member, I called the Ministry of Families and Children Development hotline, and I felt reassured when I confirmed that Social Services was already involved in this case.

*Moz*

Moz and I first talked at the end of a day of interviewing when I was packing to drive back to Victoria. I had called earlier in the day and left a message but had not heard back, so I was surprised when a soft but clear voice suggested that I drop by that afternoon. My friends in the community who lived near the reserve had drawn a map for me, and I pondered it as I drove. The directions read, “Turn right at the washing machine.” I walked up to the house, passing the fire pit, which was still scattered with the half-burned debris of clothing and shoes. Children’s belongings were scattered on the lawn. The curtains over the windows were pieces of carpet that had been tacked up, and the whole house tilted to one side.

When I knocked at the door I was invited in and found a young boy greeting me. He was about six years old, full of smiles, seemingly delighted to see a visitor. He bounced on the couch where I found a seat, and his mother and the baby were sitting nearby. Although there was a saggy, worn look to everything, the house had a warm
atmosphere. The walls were patched, and nails were visible. Moz had lived in her home for 15 years.

Her partner, the father of both children, was in the room watching TV. He had his back to me, and all I could see initially was a broad, shaved scalp. After 10 minutes of talking at his I walked around his chair to say hello. He received me warmly, but within a minute he returned to watching TV.

On the wall was a photo gallery that consisted of 15 large photos of family and friends. Moz’s partner saw me looking at the photos, and I inquired about them. The next time I visited her home we toured the gallery. She told me repeatedly that this person or that person in the pictures was a deceased brother or friend, and I was struck by the number of family members who had died so young of either suicide or a car accident.

Prior to the interview, Moz and I moved to a back bedroom and sat on a mattress on the floor. She rocked the baby as we talked, and the baby slept. Moz talked freely and with energy, focusing on her pregnancy, the birth, and the period following the birth:

That birth was such a relief. I just thought something was going to be wrong with her, and she came out fine, so that was good. The trouble was, she got sick and couldn’t hold her oxygen, so we were back in the hospital. I had to be there for days, and I stayed in her room. I suppose the fear of her not breathing got to me, and I cried and cried in the hospital. Coming home was better, but I still get sad. I don’t see people much.

Moz went on to speak of her family and the loss of important family members in her life. She talked about her sister who she thought might have had PPD. Moz said she knew who had PPD in her community; she could see it in their faces. Her sister had “it.” The mothers used their own terms to describe their depression: tension, tiredness, anger, apathy, “can’t be bothered,” weakness, relationship problems, and disillusionment with life.
Themes

In this section I identify and describe three themes that represent the women’s lives that emerged through the process of ethnographic analysis. Despite the fact that the mothers’ postpartum experiences and circumstances differed in many respects, the analysis revealed many common threads of meaning. The study themes in this chapter include Being Cut off From Family and Friends and Feeling Lonely, What’s the Point? and Not Depression, Just Depressed.

Theme 1: Being Cut off From Family and Feeling Lonely

Social withdrawal seemed to characterize all of the young women’s experiences. At some point they had been far from family. They had each become isolated in their own homes, and at the same time felt disconnected from their babies. The participants found themselves physically removed from the traditional support of family members and Elders, which contributed to their deep sense of loneliness and isolation, and they were unable to reach out to socialize. They experienced different characteristics of loneliness: loneliness in their day-to-day lives and loneliness in their intimate relationships.

Many Aboriginal people believe that reclaiming spiritual and traditional ways is the key to recovery from the intergenerational trauma and losses (Smye & Browne, 2002). All three women interviewed for this study struggled without the attendant help of family members and the traditional support and care from their home community. These relationships would have helped support them and perhaps to reclaim their spiritual and traditional ways of life as they became new mothers within their communities. Chandler and Lalonde (1998) studied suicide rates across communities. Cultural continuity is a term that that they use to describe the healing landmarks that exist in some communities (Smye, 2002. p.51). These are often political features that support the community
members in education, land claims, and self-government, with an emphasis on traditional ways of learning about their culture and environment (Smye & Browne, 2002). Chandler and Lalonde found that these are protective factors that result in more healing and less trauma in the community and that a community with healthy cultural continuity would be more able and cohesive to support community members.

Within Moz’s social world, an important connection was lost with the death of her grandmother. Moz talked about some of the traditions within her family:

Our main thing was to take the baby straight to Grandma’s house. She would hold him and sing to him in her own native tongue, . . . right till her last days. . . . She was the one who held us all together, . . . but she never got to see this little one. She helped me with her advice. “Don’t stand in the doorway!” she’d call. “Your labor will be harder!” “Your baby will come in and out as it pleases!” “Never scream because your baby will scream!” I believe in that one. With my first baby I was a baby with a baby. I was very scared.

Without traditional support, the participants described moving through the postpartum months and becoming increasingly lonely. It seems that each woman withdrew from her lifeline in her own way. They were away from home and the influence of Elders, family, and friends in their home communities. The participants each chose to spend more time in their homes, often sequestered in their bedrooms. They became more isolated. In their interviews they all talked about being away from the people who love them. Marla questioned why she had left the people who love her.

These women were feeling lonely within their intimate relationships, but they were situated in an intense relationship with babies who needed their care. They spoke about removing themselves or disconnecting from the care of their babies. The following account demonstrates this aspect of Marla’s relationship with her baby when she was feeling depressed. The mothers felt the intense responsibility of caring for their babies,
and when their partners offered support, it was not enough. They found that their babies were their responsibility, not a shared responsibility with their partners:

I did a lot of things with her—read to her, sang to her, got her books and stuff—but I noticed [when I was down] that I wasn’t doing anything with her. It was like, throw her in the walker or something and then just go lay in the room, and I’d be like, “Oh yeah, oh yeah, Elly” when she’s crying, and it’s kind of like I just lay there as if I didn’t care or something.

These women’s comments reveal the depth of their struggles to carry this responsibility. They felt especially alone and isolated. Things changed for each of them when they became mothers, and simple things such as leaving the house became more complicated. They had to put another individual’s needs first, and this experience of change was a feeling of loss for the previous way of life.

Beck (1993) identified four stages of depression in her study *Teetering on the Edge*: (a) encountering terror, (b) dying of self, (c) struggling to survive, (d) regaining control. Beck described isolation as a consequence of the second stage of PPD. Marla talked about her isolation in the last months when she lived with her boyfriend's family. It was not easy for her because of the tension between her and her boyfriend, and she was often alone in his parents’ basement. Later she described the abandonment that she felt during that time: For Marla, an experience of depression developed silently and insidiously until a family member noticed that something was happening to her. Although she had telephone contact with her mother, she still felt that she was away from most of the people who cared about her.

Marla struggled with being a new mother and having a young partner, which caused conflict in her life: Marla voiced that the move had been a mistake.
I'm regretting that [the move] because he just drank and drank and drank, and if I knew that was going to happen, I could have just stayed there where people love me and were so happy and proud of me being pregnant, instead of being somewhere else where I just spent my pregnancy. It didn't feel great at all. Every time he came home on Sunday after the weekend, I'd always be trying to pretend to be happy and act like he didn't just leave me and the baby in the basement all weekend.

I was aware that Marla felt powerless, but she tried to avoid the appearance of unhappiness in her relationship. In our interview she spoke of playing the role of happy young mother. She chose to fabricate this role and tried to be the new mother she wanted to be. She did not want to lose her relationship with her partner.

I couldn't really talk to anybody without them saying blah, blah about Jay. He is a loser. I knew he was like this and that, right? So it was really hard to talk to my dad because they just automatically agreed with me and said all these negative things about him I didn't want to hear that. I don't want to feel that way towards him. So I just kept it to myself.

Sometimes the participants' "pretended to be happy," or, conversely, they reflected back and saw that their pregnancy had taken them on a better road: "I was doing things wrong. I had started drinking again; then a big bang. When I got pregnant, I had to grow up then and there." The participants' disillusionment was reflected in their words as they referred to their relationships and anticipated future.

Marla still wanted to be part of a relationship even though it was causing her pain. First-time motherhood is characterized by change and loss of self (Beck, 1993). Marla denied the loss and pretended to be happy (Nicolson, 1999).

The study participants all alluded to the fact that they had no access to anyone with whom they could talk who would be nonjudgmental. Although Marla had "always had a load of friends," she expressed a loss of confidence that anyone, whether friend, family, or clinician, who listened could understand her particular challenges. Clemmens
(2000) noted that the ways that women interpret and negotiate the social norms of motherhood depend in part on their relationships with their peers. When I asked Marla what her relationships with her friends were like now that she was a mother, she described being part of two realities. She felt left behind by friends and said that people looked at her differently now: “It was like I had people around, but they didn’t understand.” Marla described shutting herself away from peer support, and she was not meeting people. This was compounded by her sense of guilt about her lack of responsive care for her daughter when she was feeling depressed.

In this study the women were in relationship with their boyfriends, and those relationships were not supportive even though the men involved expressed their desire to be helpful. When the mothers in this study were at home with their babies, their partners were often out with their friends. The participants’ loneliness was compounded when, as two of my informants reported, they were concerned that their partners were with other women. These women were lonely within their relationships. Oates et al. (2004) attempted to determine whether PPD is a universal experience and a cross-cultural phenomenon et al. and found that loneliness, lack of emotional and practical support, poor relationships with partners, family conflict, and tiredness contribute to unhappiness in the postpartum months. These women wanted support from their partners, friends, and family. They highlighted emotional support and assistance with the care of the baby as important, but most of all they wanted their partners to stay around.

Depressed mothers often reject their friends and even close family and believe that they themselves have been rejected (Nicholson, 1990). Mauthner (1999) observed in her study on PPD that the women describe isolation as a conflict between a narrowing of their social lives and their vision of their own lives. Mauthner’s participants wanted to
reach out to friends and family but did not allow people near. At the same time they described yearning for support. For a period of days or weeks during the postpartum months, the mothers in this study were unable to reach out and associate with people, and they isolated themselves in their rooms. Each participant described a similar scenario. For example, Jeanie longed for a connection with her sister but became reluctant to use the phone, which was compounded by the fact that she was also in a financial crisis and could not pay for her own phone.

Beck and Driscoll (2006) noted in their work on postpartum depression that mothers can feel alienated and alone if they believe that no one understands what they are experiencing. Beck and Driscoll showed that it is not unusual to be isolated in the home and become more and more afraid to go out. Having a first baby is often more isolating than subsequent births due to not having joined with a group of mothers. This is debatable as mothers with more than one child often report feelings restricted when managing two or more small children (Nicolson, 1999). This may be a reflection of the age of the mother. Social separation from their peer groups is somewhat inevitable as they care for their babies, and their lives hold different responsibilities for their babies’ care. Moreover, they have not yet established a network with other mothers with children the same age. Neither Jeanie nor Marla had connected with people in this new community.

Being away from family left Moz feeling alone and on her own. She was unable to see her partner because he was committed to his drug-rehabilitation process, and she was spending so much time without him that she could not share her feelings. Moz felt lonely within the relationship and with her extended family. She described the situation where she felt she had to be strong:
I really was on my own. I wanted to share how I was feeling with someone, ... to share the experience with somebody. Because I was so young with my first pregnancy, I didn’t know what was going on with my body. So with this one I knew what to expect, and I knew what was happening and wanted to share it, but he was out of town bettering himself [at a drug rehabilitation centre]. I had to be strong. I love my baby, and I wanted her to be good, and she was, but sometimes I could just start crying because I felt, How can I look after her? And I wished my mom and my gran were with me. It is hard all day alone [following the birth and then during the postpartum months stuck in the house]. . . . In the hospital I was getting so lonely, and I wanted him to stay with me. And he said yeah, but he was gone. Later I told him, “I did this whole pregnancy, you know.” He says he’s going to do things, and he just never comes back. He did come back that time, and he did say sorry.

Although Marla lived with Jay’s family, she found herself segregated in the basement. She had had a caesarean section, and the doctor did not want her to walk up and down the stairs:

I just started staying downstairs because the doctor didn’t want me going upstairs, so I was down, and we didn’t sleep together for about a week. I thought, I have made a mistake having a baby with him. I didn’t want to talk to anyone.

Beck (2006) reported that clinicians who work with women with PPD are aware that such women have feelings of anxiety about meeting people and going out; the participants’ descriptions echoed this. When they were depressed, the one thing that they could not do was to reach out to people. As Jeanie said, “You want people to ring you, and you want them to come to you. There’s no way you can go see them.” Marla reflected on the way that this postpartum isolation had crept up on her. She did not recognize it when it was happening, but she remembered clearly that her mother had identified it. Marla remembered a conversation four months after her baby was born:

One day my mom called. I forgot what she said to me, and she just cried on the phone because I guess she felt there was something wrong. She said, “I don’t know what Jay is doing to you”—even though I felt she had no right to say that to me. She’s like, “You are not the same Marla I know. The Marla I know loves to go to school and loves to make sure she’s happy and loves to make other people
happy and laugh.” And she’s like, “I always imagined you being a good mom. You’ve got to stop thinking negative.”

The participants discussed the importance of family and social networks. The young women in the study were isolated in their homes, and they connected to family through phone calls. As they became depressed, they found it harder to initiate calls, and their support systems broke down. One participant’s mother called her through her depressive period and encouraged her to seek ways out of the depression. This participant acknowledged the value of that connection, whereas another floundered without anyone to support her while her life spiraled into violence and destructiveness.

Marla’s strong relationship with her parent kept a doorway of communication open. When she said “This isn’t the Marla I know,” she was telling Marla that she recognized a change. She asked her daughter, “Can you start getting out more? Go visit someone.” This contact allowed Marla to tell someone about the loneliness that she felt, which helped to put it into perspective because someone close to her was able to interpret the changes as abnormal. These statements helped Marla to see herself in the context of being a new mother and to recognize the isolation that had crept into her life.

Marla was battling on two fields: with herself as a mother and with her partner, who seemed unable to support her. She wanted to give up the baby. For Marla this was compounded by a sense of guilt about her lack of responsive care for her daughter when she was feeling depressed. In addition, she felt that her partner had withdrawn from their relationship. The participants were unable to voice their needs. At three or four months postpartum the women in this study were struggling to find a balance between their needs and the needs of their babies and their partners.
The participants celebrated having a partner relationship and being what they saw as a family. However, their feelings for their partners were conflicted. It was a recurring problem, and they described the push and pull of emotions with their partners. On one hand, it was good to have a father for the baby; but on the other hand, they were unsure whether it was preferable to have their partners there, but to worry and fight with them, or to be even lonelier without them. For example, Marla said, “He was buying stuff for the baby and saying he loved us and then getting drunk. That’s a shit show.”

In each of the interviews the women described the bleakness of their situations, the taut pull of trying to be young and wanting to go out and have a good time. The transcripts contain references to alcohol consumption and drinking binges. In each case the partners used drugs, and the women struggled with the understandable turbulence that this caused in their relationship. They tried to resist the pull from friends. For example, Jeanie commented that friends would often say, “Oh, it looks like you need a drink.” So they go and get drinks, right? That was the hardest, trying to get rid of it and to stay away from that.”

Each participant resisted the pull for a while, but one was unable to do so completely. This made life more unstable and in one case there was physical abuse. Jeanie talked about the tension between her and her partner. Because she was not able to reach out for help, no one was available to counsel her through this difficult time. In the end she reacted with violence, seriously hurting her partner and getting seriously hurt herself. The catalyst for this incident might have been the isolation, loneliness, and frustration that she felt in their relationship. Aggravation from the depression—what Beck (1993) called the “spiraling down” (p. 182)—might have led to the altercation.
Moz remembered when her loneliness began: “I was pregnant and I didn’t know, because I was so into wondering where he is and what is he doing and not focusing on myself and realizing that my body is changing.” Her partner was unavailable to her because he was struggling to overcome his drug habit: “He came out when he found out I was pregnant. He decided to go to treatment and pull himself together, so that was a tough one, him being gone for so long [and my] wanting to share.” They all had a sense of being abandoned by their partners and family and were lonely as young mothers. The participants experienced a roller coaster of emotions: One minute they found themselves laughing with people; the next minute they were angry and fighting. They described being alone in literal terms and within their relationships. The optimism with which they began the postpartum months faded to apathy about their future.

Theme 2: What’s the Point?

All of the participants commented pessimistically on the future, and they found that they could not be bothered to reach out and were disinterested in social events. Moz did talk about her son’s future and she hoped to see him do well in school. She talked about her own aspirations to be a teacher but she had two children now and her baby daughter needed constant attention. She had put her own career on hold. Marla remembered the way that she felt through the depressive weeks:

People even tried to phone me, and they’d be asking questions and things, and “Hey, what are you up to?” And I’m like, “Oh, I don’t know”—just very dead on the phone. I just had everything come out negative about everything, about school, about friends, about whatever. And I was like, no, what’s the point?

Jeanie’s main support now came from her sister in Ontario, whose baby was just a little older. I asked Jeanie, “Did you phone her when you felt down?” “No, not really. I’d just look and look at the phone and hope she’d call me. I just felt distant, far away. It was
like I wasn’t really anywhere. Not really there.” It seemed that she felt a sense of loss that the people around her could not see. Her response to her family and friends of “What’s the point? What is in the future?” appears to be a normal response to the “losses” of motherhood that Beck (1996) described. Beck hypothesized that loss of control is the basic social-psychological problem in PPD. Apathy revealed the participants’ loss of aspirations for the future, which was reflected in Jeanie’s lack of energy to create a social world for herself and her six-year-old son who spent a great deal of time alone.

As I stated in the discussion of the previous theme, the participants might not have been able to identify their emotions, they had no one close with whom they could talk, and they withdrew into silence. Jeanie was vulnerable to her imminent eviction. She had little or no control of the situation, and she stopped imagining a positive future. The data clearly show how alone she felt. It was as though she was unable to react to the world around her.

Marla demonstrated a serious change in her attitude toward caring for her baby. She lost her motivation to take the baby to the drop-in group run by the public health nurse, which conveyed her loss of enthusiasm, and she was unable to invest in the future. Marla commented, “My mom asked, ‘Have you been taking Elly to the health unit or one of those places?’ . . . I said, ‘What’s the point? It’s not like we do anything anyways.’”

Beck and Driscoll (2006) found that postpartum-depressed mothers repeatedly reported feeling mechanical when they cared for their infants. They would go through the motions of feeding and changing their babies, but they described a physical component of their depressed mood in which they often found themselves “walking round the house like a zombie” (p. 84). Depression overtook the participants in Beck’s study and deprived them
of any feelings of joy as mothers. Beck (1993) noted in her paper *Teetering on the Edge* that “consuming guilt” (p. 279) is often a theme in PPD, and Marla struggled with this:

“Oh, Elly, I don’t need you any more; I’ll just give you away.” . . . I felt guilty for a long time, and then the guilt started to hurt me and I was like, Jeez, why did I say those things? . . . But the more things that went wrong with Jay and me, the more he chose to neglect—not neglect, but avoid our daughter, . . . and it was frustrating because this wasn’t his stepkid!

In her research on PPD, Mauthner (1999) found that women feel guilty about their sadness. She noted that many of her participants were reluctant to admit their depression and were “feeling low and feeling really bad about being low” (p. 35). Young mothers can feel confused during the postpartum period because there is the challenge of caring for their babies, combined with the difficulty of maintaining relationships and interconnectedness with peers while they are young mothers (Logsdon et al., 2005).

In the second theme, What’s the Point? the participants described their apathy towards the future. This may be a transient expression of their postpartum feelings or hold embedded cultural meaning because of the context of their lives. The next theme, Not Depression, Just Depressed, illustrates the subtle way that the participants discussed their postpartum experiences with regard to feeling depressed.

*Theme 3: Not Naming Depression, but Just Being Depressed*

The mothers in this study found it difficult to explain or name depression, and yet that was what they described. They used phrases such as “It’s hard, . . . it’s really, really hard” to describes their emotions; they expressed a sense of emptiness and nothingness. Like the participants in Nicholson’s (1999) study, which focused on the participants’ subjective experience of PPD, my study participants also denied having PPD; in fact, at one point or another they insisted that they did not have depression during the postpartum
months. For example, Marla said, “If I had it, I wasn’t sure. I just kept in my room for
days and looked at her [the baby]. I didn’t really want my life at all.” It renders mothers
unable to recognize or name the symptoms of depression, and they tend to believe that it
is inappropriate to seek treatment for PPD (Mauthner, 1999). Moz did not think that she
had depression: “I didn’t think I was really depressed; I just thought it was life.” This
suggests that she felt that the term PPD did not fit with what she was experiencing and
that her experiences were normal. She felt that she had to keep everything going for the
sake of her family.

Jeanie said,

I think I just got so tired. She [the baby] was always beside me; I was pretty much
 glued to her. And then I was crying for nothing; I’d just go in there and cry. I’d be
just always in the bedroom, just tired and drained out. Trust me, I was down, and
he [her boyfriend] wasn’t here. My mom phoned, and she was telling me my son
was crying for me. I couldn’t take him; I didn’t have a place. I felt sad about that
because he’d be crying on the phone. I suppose that brought me down, so I got
sad.

Moz commented on the depression she saw in the First Nations reserve where she
lived: “I think it’s something that is held with them. I do know some moms who
developed PPD but never talked about it.” I asked how she would recognize someone
with postpartum depression: “Just the expression on their faces and the stress, the tone of
their voice. My sister was one of those, so I got to watch her. That’s how I felt.” Moz was
expressing her own understanding of PPD. She continued: “I was depressed, alone in the
hospital. I done a lot of crying.” At that time it appears she saw herself as depressed.
Feeling a commitment to mothering and then feeling trapped in the mothering role are
common emotions for adolescent mothers (Logsdon et al., 2005). This was illustrated in
my study. Marla felt the initial commitment that Logsdon et al. described. She imagined
“getting a house on his reserve and having more kids; that’s all I was thinking about. I was just thinking about a family.” Shortly after the baby was born, Marla commented that she had made a “big mistake having a baby. What am I doing? Why did I have a kid right now?” She now realized that she was not going to live on the reserve with Jay and that she had to rethink her future. Problems like this caused these women to feel despondent. Although they did not name this feeling as PPD, they each spoke about being depressed during the postpartum months. As Marla said, “not depression; just depressed.” Nicolson (1999) concluded in her study *Loss Happiness and Postpartum Depression* that “motherhood is tough. Women’s ambivalence towards their role is rarely acknowledged” (p. 176).

Nicolson (1999) found that women assume that depression is a reasonable response to the responsibilities of being a mother and therefore a normal part of motherhood. The combination of motherhood and depression together are challenging for a mother to assimilate (Mauthner, 1999). The participants in this study all expressed disappointment about the personal goals that they had set for themselves and hoped to attain. Motherhood is a period of transition, and that factors that might have triggered depression were difficult for them to recognize subjectively. Marla reflected on the different community she was in now.

I just wanted something because being here and not knowing anyone was really hard. Because I grew up in the north so all my friends and all my family are there, all the people who would support me in every way were not around so I had to do something. My mom told me get out there and adopt someone, someone like your sister someone to talk to.

The interviewees commented on their negative interactions with their partners. When Moz told me about her early postpartum weeks, I imagined her on a teeter-totter with her end down and no one on the other side to bring her back up—the mother and
baby at one end, too heavy to be lifted up by her partner. Although they wanted to talk to their partners about their feelings, they believed that they would not be understood. The image of a teeter-totter is analogous to the weighted feeling in the women’s relationships as though they recognized that they were down and hoped that their partners could exert themselves to lift them up again.

As the interviews proceeded, they talked of their depression from their own subjective stance. In their descriptions each of them used words such as *sad, lonely, tearful, removed,* and *disconnected,* but they did not say explicitly that they felt depressed. It is interesting that these participants had not understood their experiences as depression; they referred to their feelings as not depression, but “just depressed.” Although she did not name it, Marla described a depressive period four months postpartum: “I was like I don’t even want to live, and I didn’t even say just kidding or anything; I just said it: . . . I don’t want to live any more.” It is difficult to know how serious this event was, but the following sentence is telling of her despair: “‘I don’t want you any more, Elly. Your dad doesn’t want me, and I don’t want you.’” The young women’s self-worth was low. They experienced apathy in their everyday world and hid their feelings and themselves from social situations in which they might feel judged.

Marla was expressing her feeling that she is unworthy. I did not ask the study participants specifically about this feeling, but it appears that they experienced a loss of self-worth during their depressive periods. In her paper “A Legacy of Betrayal,” Hurst (1997) looked at the demoralization of women with depression and referred to the loss of self-worth that women who are depressed feel.

Marla remembered an incident in which she was speaking harshly to her baby: “I found myself crying away; like, ‘Why did I say those things to you?’ Even though she
couldn’t understand the words, she could tell how I felt, and I felt so guilty for a long time.” Women often have negative feelings for their babies during PPD. Admitting to having these feelings, even to family, is compounded by a sense of guilt, weakness, and failure (Nicolson, 1999). It is hard for people who are depressed to extend themselves to care for someone else (Beck, 1992, 2006). Even as the depression lifts, mothers can remain haunted by guilt as they remember how they interacted with their babies during the depressed times. Without understanding the contextual factors that may be making them depressed, they tend to think that they are bad mothers—“failed motherhood,” as Nicolson (1999, p. 192) called it. Depression is known to carry stigma and guilt, and it was easier not to acknowledge to themselves or people around them that they might have depression. The theme Not Depression, Just Depressed expresses the participants’ ambivalent feelings of sadness and depression during the postpartum months.

Summary

As the findings illustrate, the participants in this study talked about their postpartum experiences. There were three general themes from the data analysis. The first theme of isolation relates to the experience of being away from home and family and being isolated in current relationships. Two of the young women had left their home communities to be with their Boyfriends, but they found that life as a new mother was very demanding and isolating. They did not have a support network of family, extended family, and Elders in their new community. However, even Moz, who lived at home in her own community, found herself isolated and lonely. She pined for the mentorship of her grandmother, who had died during this pregnancy.
The second theme relates to the feeling of despondency to which the participants referred when they spoke of their lives in the future. They expressed feelings of apathy and indifference; they asked, "What's the point?"

The third theme suggests that the young Aboriginal mothers interviewed in this study might have found it difficult to identify their postpartum experiences as depression. In the following chapter I discuss the study findings and shed light on their significance.
CHAPTER FIVE:

DISCUSSION

The focus of this study was the experience of young Aboriginal mothers in the postpartum months. The central research question guiding the analysis was, How do young Aboriginal mothers experience the postpartum period? Using an inductive approach as part of my method helped to describe the participants’ culture-sharing group. I used one-to-one interviews to discover different aspects of their day-to-day lives to understand what it is like to be a young Aboriginal mother. I gathered the self-reported experiences of the three mothers whom I interviewed, included my own participant observations, and analyzed the data using an ethnographic research approach (Spradley, 1979). In this chapter I discuss the importance of the study, its limitations, and the implications for nursing practice and future research.

Significance of the Study

This study revealed depression within the participants’ postpartum experiences that was not identified or treated during that time. It is easy to understand from the themes that the participants were often expressing their depressed mood. There are many examples in the data of their retrospective realization that they did have prolonged periods of depression. The significance of the study is the light that it sheds on the experiences of these three young mothers as they live through the postpartum months. It broadens our understanding of the realm of PPD in this cultural context and alerts healthcare professionals to reach out to young mothers.
Summary of Themes

In my study I examined postpartum experiences from the perspective of young Aboriginal mothers. Three themes that arose from the data analysis inform the framework of this discussion: (a) being cut off from family and feeling lonely, (b) what’s the point? and (c) not depression, just depressed.

The first theme speaks to the way that the participants’ social world changed in the postpartum period. Social withdrawal characterized their experiences at varying times through the postpartum months; it resulted in changes in their social and everyday interpersonal lives, the way that they felt about themselves and their self-concept as individuals and mothers. It is generally accepted that young mothers will experience a significant transition into a new lifestyle when they have to be responsible for a baby, and the participants in this study talked about those changes (Beck, 1992; Mauthner, 1999; Nicholson, 1999).

Logsdon et al. (2005) looked at the effectiveness of social support for adolescents with PPD. Her sample of 128 adolescent mothers received a variety of interventions that caused no significant changes in their depressive symptoms at six weeks postpartum. Logsdon found that low levels of support are a strong predictor of PPD, which I confirmed in my study. Logsdon, Wisner, & Pinto-Foltz, (2006) then looked at the impact of PPD on the maternal role in a study of healthcare services available to mothers with PPD. She also found that mothers are the primary caregivers for their infants. In my study I found the participants to be largely responsible for the care of their infants. The findings indicate that they struggled with life stressors as part of their responsibility as mothers. Together with the added partnership problems, they were at risk of having postpartum depression and a potentially more difficult relationship with their infants.
This study confirmed the literature that demonstrated that mothers with depression do not seek treatment for their depressive symptoms (Flynn et al., 2004). In Flynn’s study mothers were screened for maternal depression in a pediatric clinic. This study showed that 31% had clinical depression, and 78% did not have any form of treatment for it. My study findings suggest unrecognized and unreported depression in the postpartum period. When the participants felt depressed, they did not have a social network to support them, and they actually withdrew from possible lifelines. It is known that experiencing the transition into motherhood within a supportive social network with other mothers helps women to check out their emotional responses to the changes of motherhood and offers them peer mentorship and practical assistance from other women (Mauthner, 1999).

The participants in this study chose not to socialize; they were reluctant to reach out even to family and friends. Their relationships with their peers had faded, and they did not associate with peers or initiate calls to them. This was relevant to their postpartum mood because socialization is known to be a mediator of depression for adolescent mothers (Beck, 1992). This confirms the work of Birkeland (2005), who examined the social and individual challenges of 149 adolescent mothers to understand the factors that contribute to PPD. Birkeland described the first year postpartum as a stressful period for adolescent mothers regardless of their ethnic background. She focused on the overlap between adolescent motherhood and PPD and confirmed that social isolation is a strong influence on PPD in this adolescent cohort. Birkeland’s study participants also described their feelings regarding the pressure of motherhood, compounded by the pressure of adolescence. In both Birkeland’s work and this study, the participants expressed the
burden of living with multiple stressors as part of their day-to-day lives, which was manifested in their apathy and withdrawal from social connections.

My interpretation of the study findings is that the participants had some awareness of PPD, but they did not voice this. They suppressed their own feelings to disguise their depression. Negative stereotypes of young Aboriginal mothers are common and perpetuated by social problems such as living below the poverty line (Browne and Fiske, 2001). Aboriginal women face discriminatory judgments in their connection with social services and health care services in the community. Two participants had been apprehended by government services in childhood. The unfounded assumptions that the negative stereotype perpetuate may have led to the women in this study to feeling stigmatized and blamed and therefore reluctant to seek support when they felt depressed.

Their stories reveal their postpartum feelings, and they described motherhood as fraught with contradictions and felt that becoming a mother is not always a happy event. In “Loss, Happiness, and Postpartum Depression: The Ultimate Paradox,” Nicolson (1999) described a study of 24 women who were interviewed three times during the childbearing year at one, three, and six months postpartum. She argued that childbirth and parenthood can be a disruptive event. The article focuses on the way that women account for their experiences in the postpartum months. The second theme of my study, “What’s the point?” parallels some of Nicolson’s results. She found that the new baby represents a loss of the previously anticipated future. The theme revealed the participant’s apathy towards their altered future. For a period of time they could not move forward. My study confirmed Nicolson’s findings of a pervasive sense of loss that the mothers in both the studies experienced.
There is a tendency for mothers to normalize their depression in the postpartum months, and the participants, like many mothers, suffered badly through the postpartum period. Mauthner’s (1999) qualitative work suggests that PPD is more likely to occur when mothers are unable to express their feelings. The participants in this study chose not to name their feelings of depression as PPD, which confirms Mauthner’s conclusions. Sharing their experiences might have resulted in fewer depressive feelings.

The theme in my study, “Not depression, just depressed,” alludes to this loss of voice. The participants lost the ability to ask for recognition and help with their depressed feelings, and this deepened their depression. Alternatively, depression might somehow be normalized as a “health burden” (Dion-Stout, 2005, p. 22) for Aboriginal women. According to Mauthner (1999), loss of voice and loss of relationship feed off each other and create a vicious cycle. In this study the participants appeared confused about their postpartum feelings. Mauthner found that the women with PPD in her study were confounded by their feelings and admitted to feeling a stigma associated with PPD, which is a barrier to mental-health treatment for PPD (Logsdon et al., 2006). This is reflected in my study.

My study also confirmed the idea that postpartum-depressed women make an active and conscious decision to silence their own voices. Cultural discourses can reinforce the stereotypes of particular groups and therefore do not acknowledge them as an oppressive form of cultural domination over marginalized groups such as the study participants. For example, the dominant Eurocentric culture is responsible for the discourse of the nuclear family, which is widely regarded as the powerful norm, and anything different is considered as deviating from the cultural norm. However, for many Aboriginal peoples family is a much broader concept than nuclear family.
The mothers in this study were in transition into a new parenting role as they moved from adolescent to adolescent mother. In trying to explain those feelings to me, all of the participants recollected being down or depressed. Marla understood that she had had “it.” She described the ambiguities of her feelings when she had depression as “not depression, just depressed.” Gilligan (1982) found that many adolescent women write off and suppress their feelings when they are faced with societal pressure to conform, and the study participants appeared to do that. For example, when she faced being left alone, Marla chose to “pretend to be happy.” The literature identified particular indicators that healthcare professionals should note during postpartum contact (Beck, 2000; O’Hara & Swain, 1996), but this group may not have been identified because the standard screening tests are not sensitive to adolescents or Aboriginal culture.

The participants described being unable to share their feelings at some point. Looking back to a few months postpartum, Marla wondered whether she had PPD:

I don’t know if it is rare to get PPD, but maybe I had it. I was going through it because it just felt like everything was just wrong and everything that was going to happen in the future was just worthless.

At this time Marla stayed in her room and turned away from the support of family, friends, and partners. She understood PPD as something to “keep to myself.” Perhaps Marla was ashamed of these feelings.

This confirms the findings of Beck (2002), who described PPD, as a “chameleon-like illness” (p. 462) with many different presentations that complicate health professionals’ recognition of what mothers need. This is compounded by a long tradition of normalizing PPD and anxiety (Mauthner, 1999). PDD is seen as an individual problem, which models the North American cultural view of health as an individual
responsibility. This concept does not acknowledge that health is influenced by a social and political context (Smye 2006 p.42).

A typical health clinic might not easily detect a problem, and the young women in this study would not easily have divulged their depression to anyone. They were not identified as having PPD even though they exhibited many of the signs and symptoms. Understandably, this was not recognized during two women’s immunization visits, and neither woman sought to join a group or attend a drop-in group where a nurse might have detected it. Standard testing for PPD (see Implications for Practice) would not identify many of the feelings of the mothers in this study, who reported feeling changed, abandoned and betrayed, pulled and pressured, confused, and as though they were carrying a weight. But, as in other studies that I mentioned above, they also reported a sense of loss, depressed mood, withdrawal, and isolation.

Leadbeater and Linares (1992) looked at the relationship between depression, stressful life events, and social supports and found that depressed adolescent mothers who are coping with concurrent stressful life events are impaired by depression. They suggested that it might be related to perceiving life events as negative as well as being socially isolated, which, in turn, creates greater stress. Other research that examined depressed and socially isolated mothers found that they had an increased risk for continued depression and problem maternal behaviors (Lesser, Koniak-Griffin, & Anderson, 1999). The study participants were struggling with poor and insecure housing and were disadvantaged by being under these constraints.

Canadian census data reveal that more Aboriginal people than before are living away from the reserve and experience disconnection from their family and traditional healers (Statistics Canada, 2006). Young Aboriginal mothers are often new in a
community, and when they have no family social scene or party scene, they become isolated (Statistics Canada, 2006). Jeanie and Marla both talked about their lack of connection in the community, which fostered more seclusion. Coming from different smaller communities, these women had never had the challenge of seeking out new friendships, and it appears that the trouble they had settling into a new social network and getting connected contributed to their isolation and depression. The literature suggested that mental health services and health promotion must be directed at both individual and broader community levels. For some mothers this would be an appropriate time for extra support and teaching related to infant health and development. The emotional isolation, together with the physical aspect of withdrawal—"just staying in the bedroom"—is recognized as a catalyst for longer-term depression (Beck, 1998b). Marla's mother recognized that her daughter was spending too much time at home alone and urged her to start getting out more or visit someone.

It is recognized that second and subsequent births may find mothers socially isolated (Beck, 1992). Mauthner (1999) described the physical isolation that the first-time mothers in her study were feeling compared to mothers with other children, whom she found often created a network with other mothers. Semprevivo (1996) in her dissertation on the lived experience of PPD among a sample of women diagnosed with PPD reported that they found solace in isolation. It was an escape from the critical eye of the world. Many women in her study were consumed with guilt about their thoughts and wanted to hide themselves from possible critics. It appears that admitting negative feelings such as depression and being overwhelmed is admitting to personal weakness and somehow inappropriate as a mother or a part of motherhood. They did not recognize depression as a reaction to the difficulties that they were facing in their day-to-day lives. Like the
mothers in Semprevivo's work, the mothers in my study found that isolation shielded them from the gaze of the outside world.

The women in this study fit into a socioeconomic group with a variety of contextual factors that contributed to their stress of being new mothers. Statistics Canada (1996) found demographic evidence that Aboriginal mothers are more likely to live in poverty. The 2006 Canadian Census revealed a different age distribution between Aboriginal and non-Aboriginal mothers in that 55% of Aboriginal mothers are under 25 years of age, and 9% are under 18 years of age (Statistics Canada, 2006). This is reflected in the women in this study, who were dealing with the effects of material poverty and the effects of the poverty that resulted from the loss of culture and identity. They were disenfranchised from traditional ways. This was reflected in this study. It appears that the participants were culturally unsafe, cast in a negative stereotype of young Aboriginal mothers and were thus reluctant to expose their vulnerability to healthcare professionals who represented the dominant culture.

Study Limitations

It is important to consider the limitations of this study. Although the findings illuminate the experiences of young Aboriginal mothers in the postpartum months, they are generated from a small number. Questions about the adequacy of the number of participants are sometimes raised, especially in qualitative studies such as this. Appleton (1997) suggests that the interpretation of study findings occurs through the researcher's familiarity with the data. When discussing the size of sample Appleton suggests that it is important to keep the samples small and well chosen (Appleton, 1997). The debate about the adequacy of the sample size, which is most often a smaller number in a qualitative than in a quantitative study, is usually about whether it is an adequate number to ensure
trustworthiness (Morrow, 2005). According to Pollio, Henley, and Craig (1997), an adequate “thematic pattern is often provided by three or five interview transcripts” (p. 51). Ultimately, sampling procedures—“quality, length, and depth of interview data; and variety of evidence” (Morrow, 2005, p. 255)—are far more important than sample size. I believe that richness of the study data that I obtained compensated for a small number of participants.

Although the study findings are enriched by the extensive descriptions of the three female participants that corroborate each other’s experience, they are limited in that they are not generalizable to a wider population (Madison, 2005).

Implications for Practice

Screening for PPD in the population of young Aboriginal women requires a culturally meaningful and holistic approach; otherwise, cases of PPD will remain hidden. Aboriginal peoples have a well-reported tendency not to use the mental health services provided by the dominant culture (McCormick, 1997) and to stay away from the Western concepts of a medical model that does not respect their cultural identity. This naturally leads to the conclusion that if nothing is known about the experiences of young Aboriginal mothers in the postpartum period, then there will continue to be limited resources and services.

This study shows that the participants had depression and that they did not disclose it to healthcare professionals or their families. Screening for PPD in the population of young Aboriginal women in this town requires a culturally meaningful and holistic approach to avoid keeping cases of PPD hidden. This group may not have been identified because the standard screening tests are not culturally sensitive to adolescent culture or Aboriginal culture. This mirrors the work of Clemmens (2000), who suggested
that more sensitive instruments are needed to identify depression in adolescent mothers. According to work by Foster (2006) health care providers can attend to cultural sensitivity by not trivializing aspects of Aboriginal culture that they do not understand and by recognizing their own assumptions about their clients. An example might be when a client appears reticent to talk and the nurse too quickly assumes that their quietness signifies they have nothing more to say (Foster, 2006). Whereas this might demonstrate that the client is actually concerned about their privacy and safety. Browne (1993) insists that nurses, as a fundamental ethic of their practice, must convey their respect for a person through recognition and unconditional acceptance of the values of the client. An affirming encounter might be exemplified by a healthcare worker who listened with an understanding of their own assumptions and the value judgments that the mainstream healthcare system perpetrated. In this study the participants, when asked about their emotional well being in the postpartum period, had not felt safe to share difficult “truth-telling” within the mainstream health service delivery. When a young Aboriginal mother was able to talk about violence in her relationship with out the value judgment she could then analyze her situation without the over ridding need to protect herself from judgments that had demeaned her in other healthcare interactions.

Two study participants referred to the good nursing care that they had received before they had their babies but did not mention any connection with healthcare support after the first few days postpartum. Many women are left without a connection to public health services. If they are not first-time mothers, they may receive only a phone call from a public health nurse. It is likely that the nurse will ask them how they are getting on and that often they will reply that they are doing okay to avoid scrutiny or what they may consider criticism. An important implication for practice is the recognition of the
disconnection between pre- and postnatal care. Women are more motivated to connect with healthcare services during the pregnancy, but during the postpartum months they find talking about feelings difficult and conceal their needs (Dennis & Chung-Lee, 2006).

Nursing services encourage some continuity of care during the prenatal months, but this should be emphasized more throughout the postpartum. McCormick’s research with Aboriginal peoples (1997) suggested that the traditional Aboriginal person is more likely to receive help from family, friends, and traditional healers than from mainstream mental health service providers. Stiver and Miller (1998), found that women who were listened to in the vulnerable postpartum months were better able to negotiate their depressive feelings 1988) An Aboriginal person trained to make a listening visit may have been able to support these mothers and prevent depressive reactions. If women are unwilling or unable to attend clinics, outreach and home-based services can be provided. For example, telephone-based support can assist mothers with PPD at home (Beck, 1995).

Directions for Future Research

Several stimulating questions emerge from this study. It is evident that more research is needed to highlight the voices of adolescent Aboriginal mothers to help health practitioners to understand the needs and perspectives of this group. More subjective knowledge of the postpartum experiences of depression in the postpartum months would contribute to the development of appropriate health services and offer ways to work with the strengths and resiliency that young Aboriginal mothers have.

Are there new screening methods that are better able to detect depression in this group? Further research on PPD in this participant group should include a culturally
relevant depression scale that goes further than Beck’s (2002) scale to account for the presentation of PPD in adolescent mothers.

Research is also needed to learn more about the experiences of adolescent fathers during the postpartum period. What is the experience of parenthood for adolescent fathers? How are their lives affected? It is important to hear their subjective accounts, and research with Aboriginal fathers is beginning. In Ball, Roberge, Joe, & George, (2007) *Fatherhood: Indigenous Men’s Journeys*, the fathers discussed and critiqued the long-lasting, harmful impacts of residential school and the intergenerational impacts. Breaking this cycle by learning to be a parent is a challenge for fathers who themselves have a negative or poor example to follow. Aboriginal fathers are slowly inventing their own ways to have positive relationships with their children and are becoming good role models (Ball, 2006). Hearing from the next generation of adolescent parents would be helpful in planning ways to engage them in their parenting role and to support them and younger Aboriginal mothers.

The findings indicate that the participants struggled with life stressors and partnership problems and were at risk of having PPD and potentially a more difficult relationship with their infants. To address these problems, it is important to focus more qualitative research on the subjective experiences of adolescent mothers and depression to identify what the participants perceive as support and how it mediates the long-term effects of PPD.

The literature on PPD stressed the fact that the mother’s role is crucial in infant development and maternal PPD. PPD may have a long-term detrimental impact on the mother and child (Beck, 1998b). There are a higher incidence of PPD in adolescent mothers and higher rates of depression in Aboriginal women than in the general
population of women. The findings from my study suggest that future research needs to center on the variables that contribute to depression in adolescent mothers and specifically on what support works for the cultural group represented in this study.

Conclusion

The participants in this study spoke of loneliness and isolation. Their descriptions of their postpartum experiences uncovered the backdrop of their lives and a disturbing pattern of isolation and despondency in the postpartum period. This research sheds light on their isolation from friends, family, the community of Elders, and their cultural traditions and reveals subtle aspects of the participants' lives such as their inner feelings about depression and their reticence to name depression in their lives. The overall picture presented in this thesis is that of young women isolated from important mentors, with a tenuous connection to supportive relationships.

It is important that we understand more about the experiences of young Aboriginal mothers, what their lives entail, and the support that they need. To extend the metaphor of a woven cloth, I believe that the participants' lives consist of strong traditional threads. Some are severed and torn, and the challenge is to understand where to begin the necessary repairs. I suggest that these young women can restore the tapestry of their lives with strong threads to improve their futures. This is a shared responsibility. To help these young Aboriginal women, a critical awareness of the historical roots that have shaped people's lives today is important for nurses and healthcare professionals. This knowledge will help nurses to understand the social (health) and political changes that have impacted their clients' lives and enable them to better promote the health of young Aboriginal mothers and their families.
REFERENCES


Foster, C. What nurses should know when working in Aboriginal communities. Canadian Nurse, 102, (4) 28-31.


University of Victoria (2003) Protocols and principles for conducting research in an indigenous context. University of Victoria Faculty of Human and Social Development.


APPENDIX A:

EDINBURGH POSTNATAL DEPRESSION SCALE 1 (EPDS)

Name: ___________________________ Address: ___________________________

Your Date of Birth: __________________________________________________________________________

Baby’s Date of Birth: ___________________________ Phone: ___________________________

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

Here is an example, already completed.

I have felt happy:

Yes, all the time

Yes, most of the time. This would mean: “I have felt happy most of the time” during the past week.

No, not very often Please complete the other questions in the same way.

No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things *6. Things have been getting on top of me

As much as I always could Yes, most of the time I haven’t been able

Not quite so much now to cope at all

Definitely not so much now yes, sometimes I haven’t been coping as well

Not at all as usual

No, most of the time I have copied quite well

2. I have looked forward with enjoyment to things No, I have been coping as well as ever

As much as I ever did

Rather less than I used to *7 I have been so unhappy that I have had difficulty sleeping
Definitely less than I used to Yes, most of the time
Hardly at all Yes, sometimes
Not very often
*3. I have blamed myself unnecessarily when things went wrong
Yes, most of the time *8 I have felt sad or miserable
Yes, some of the time Yes, most of the time
Not very often Yes, quite often
No, never Not very often
No, not at all

4. I have been anxious or worried for no good reason
No, not at all *9 I have been so unhappy that I have been crying
Hardly ever Yes, most of the time
Yes, sometimes Yes, quite often
Yes, very often Only occasionally
No, never

*5 I have felt scared or panicky for no very good reason
Yes, quite a lot *10 The thought of harming myself has occurred to me
Yes, sometimes Yes, quite often
No, not much Sometimes
No, not at all Hardly ever
Never

Administered/Reviewed by ___________________________ Date ________________

(Cox et al., 1987)
APPENDIX B:

LETTER OF APPLICATION TO NUU CHAH NULTH RESEARCH
ETHICS COMMITTEE TO CONDUCT RESEARCH
AND PARTICIPANT WITHDRAWAL FORM

(1) Letter of Application to Nuu-chah-nulth Ethics Committee

I am in the Master’s program for nurses at the University of Victoria. I have been trying to decide what to do as a final project and keep coming back to my area of interest with mothers and babes. I would like your permission to make contact with your band nurse to discuss a small research project for my thesis.

I see a project emerging (and an eventual thesis) that could help me better understand the challenges of being a new parent in . . . . I am interested in meeting with a small group this Fall, perhaps 4-6 young mums, who could tell me about their early parenting experiences over a few meetings. I have ideas from my work with a Pregnancy Outreach Program in Victoria and would like to come to visit and talk about them and to provide any information you would like or require at this point about the project. I can drive up to meet with any interested parties. I can be reached by phone at or email,

My interest in nursing has long been focused on mother and babe. I have been a midwife, nurse, and lactation consultant. My last work was as the nurse coordinator with Best Babies at the Neighbourhood House in Esquimalt. I have visited the Esquimalt and Songhees Reserves many times and really enjoyed both communities.

I would like to join a mother and baby group that can teach me about the challenges they face and help me to produce a postpartum teaching method, perhaps in the form of a manual that truly is brought forth from the people involved. I would like to invite moms to attend 4-5 small group meetings, and would offer nutritional vouchers and/or bus tickets or whatever would be appropriate for acknowledging their time and participation. Of course I will be more specific when I ask for ethics approval from yourselves and the university.

On the way through my course work I have read widely in postpartum depression. I have attempted to review it critically and to see a broad perspective. One of the assumptions is that family support helps women. I also observed that a sense of loss is the major theme that women with postpartum depression face. First Nations women I have spoken to didn’t look at postpartum depression in recognized ways, and didn’t call their experiences depression perhaps because they had family and community support. I would like to come to Port Alberni with some ideas but more so to realize ideas about what support works for young mums facing the postpartum challenges during their first year with a baby.
There are many examples of research that exploits the people being researched and I wish to be very sensitive to this as I work on this project. I believe there is valuable knowledge to be shared. Thank you for your consideration.

Sincerely yours,

Hazell Penn
RN BSN
(2) Research Ethics Committee Research Participant Withdrawal Form

<table>
<thead>
<tr>
<th>Date of withdrawal</th>
<th>June 30, 2004</th>
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<tbody>
<tr>
<td>Name of Participant</td>
<td>Jane Smith</td>
</tr>
<tr>
<td>Participant code</td>
<td>NCN 1</td>
</tr>
<tr>
<td>Title of research project</td>
<td>NCN Research Methods</td>
</tr>
<tr>
<td>Name of principal researcher</td>
<td>John Smith</td>
</tr>
<tr>
<td>Nuu-chah-nulth community</td>
<td>Nuu-chah-nulth</td>
</tr>
<tr>
<td>Date data destroyed</td>
<td>July 10, 2004</td>
</tr>
<tr>
<td>Name of person who destroyed data</td>
<td>Joan Smith</td>
</tr>
</tbody>
</table>

Nuu-chah-nulth Research Ethics Committee Research Participant Withdrawal Form. The Nuu chah nulth Ethics Committee have suggested I use this form, and it will be included in the information/consent package.

On June 30, 2004 Jane Smith, participant, withdrew from the study entitled NCN Research Methods (title of project) which was being conducted by John Smith (name of principal researcher) in the community of Nuu-chah-nulth (Nuu-chah-nulth community).

As per the agreement with the Nuu-chah-nulth Research Ethics Committee, the data will be destroyed within 10 working days of the participant’s withdrawal from the study.

The data collected up to that point was destroyed on July 10, 2004, by Joan Smith (name of person who destroyed data).
By signing this document, I agree that the above statements are true to the best of my knowledge.

Signature of Researcher  Signature of Participant

Date Signed  Date Signed

Signature of Witness  Signature of Witness

Date Signed  Date Signed

*A copy of this document will be provided to you and one kept by the researcher.*
APPENDIX C:

INFORMATION LETTER AND CONSENT FORM

The information letter will inform the participants of the dates and conditions of their participation as the work begins. All aspects of their participation are detailed in the consent forms.

“What Are Aboriginal Adolescent Mothers’ Experiences of Postpartum Depression?”

You are being invited to participate in a study entitled Adolescent Women’s Postpartum Experiences in an Aboriginal Community that is being conducted by Hazell Penn.

- I am a graduate student with the University of Victoria in the Department of Nursing. I want to recruit 6 adolescent moms with new babies between newborn to six months of age.

- We will meet twice for individual interviews of 1 hour 1-2 weeks apart.

- Following the individual interviews, we will meet twice in a group with other adolescent mothers with new babies for discussion about your experience of being a new mom and any sadness you may be experiencing at this time.

- The group interviews will last about 1:5 hours and will be approximately 2 weeks apart.

- Your participation is completely voluntary and you can withdraw at any time without explanation.

- You will be provided a modest compensation for your participation in an interview and/or focus group.

- For more information I can be contacted by leaving your name and number at the Native Friendship Centre.
Consent Form

School of Nursing
University of Victoria

Participant Consent Form
Individual Interview

Adolescent Women’s Postpartum Experiences in an Aboriginal Community

What are Aboriginal Adolescent Mothers’ Experiences of Postpartum Depression?

You are being invited to participate in a study entitled Adolescent Women’s Postpartum Experiences in an Aboriginal Community that is being conducted by Hazell Penn

Hazell Penn is a graduate student with the University of Victoria in the department of Nursing. You may contact her if you have further questions by calling her at 250-595-5925.

As a graduate student, Hazell Penn is required to conduct research as part of the requirements for a degree in Master’s of Nursing. The research is being conducted under the supervision of Dr Elizabeth Banister. You may contact her at 250-472-4703. You may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate Vice-President, Research at the University of Victoria (250-472-4545).

The purpose of this research project is to understand Aboriginal adolescent mothers’ postpartum experiences with postpartum depression.

“What are Aboriginal Adolescent Mothers’ Experiences of Postpartum Depression?”

You are asked to attend:

- Two individual interviews lasting 1 hour
- Two group meetings with approximately 6 other participants lasting 1.5 hours each

You will have to travel to and from the interviews locations and the meetings at the Port Alberni Native Friendship Center or a location of your choice where we can record the interview.

Each of the four meetings will be tape recorded to record what you say.

Please read the next pages and ask me any questions you need answered before you sign to give your consent to participate. Thanks, Hazell.

I understand time is precious and giving your time is an inconvenience. I can help you by giving you $25 dollars for participating, paying for your bus travel, and giving you a snack.

If you think you’ll need childcare, let me know.
There is the possibility that there could be emotional or psychological discomfort involved when discussing postpartum feelings of depression.

If you seem to be emotionally or psychologically upset in the interview, I will make an assessment and if necessary I will refer you to the appropriate contact people in the community. The Nuu chah nulth Nursing program will be my main resource and I plan to meet a nursing representative who will collaborate with me to secure a pathway for you as needed.

Furthermore, my supervisor is a Registered Nurse and Registered Psychologist and will be available by cell phone for consultation as needed during and after data collection. This information will be kept confidential. You do not need to disclose any information that you are not comfortable to share.

If people know you are part of this study, you may find some are judgmental of you because of the term “depression” and people’s negative views of mental health.

The potential benefits of your participation in this research include: You will be able to express your feelings as you discuss your postpartum experiences. Several studies have shown that the experience of “listening- visits” in the first months postpartum has helped women to “cope.” The empathetic listening will help to uncover your strengths. Sharing within the group will offer the potential for obtaining new perspectives about your experience. Also the group experience will help break your isolation and help you feel more part of the adolescent mother community.

The feelings you share will contribute to knowledge of adolescent women’s experience of being postpartum in a First Nations community. It will provide information for the community, from a First Nations perspective. It can be used to support women in the future by sharing the experience of being an adolescent mother in the community. Community members and healthcare providers can gain insight and offer new support to adolescent mothers in the community. For example, if you feel isolated, community members may find new ways of including you. The feelings that you express can be summarized and shared in the healthcare community and be used to support women in the community in the future.

The information you share will contribute to knowledge of adolescent women’s experiences of being postpartum in a First Nations Community. The research results will provide broaden our understanding of important cultural values that are present for new mothers and their families.

It is important for you to know it is unethical to provide undue compensation or inducement to research participants and, if you agree to participate in this study, the form of compensation (detailed below) must not be coercive. If you would not otherwise choose not to participate if the compensation were not offered, then you should decline. I believe it is important to provide some modest compensation to you for participation in this study. Your time and participation are valuable. I wish to acknowledge your time spent and the added difficulty you may have in participating in the research while being a mother. I will give $25 dollars to each participant when they attend a meeting or an
individual interview. I will offer to cover bus transportation costs. I will provide a nutritious snack for you and I will arrange for childcare if you feel it will be helpful.

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study your data will not be used. It will be destroyed. You will still receive compensation for any meetings you attended.

Your information will be kept confidential. Names will not be used. The data will be kept secure in a locked space. Data collected up to that point would be destroyed (within 10 working days). Data will be physically and confidentially destroyed (shredded) and computer generated work will be deleted.

To make sure that you continue to consent to participate in this research, I will review the consent form with you each time we meet. I will ask you to initial and date the consent form to show your continuing consent to participation.

In order to protect your privacy, the following measures have been taken:

No names will be used on documentation, audiotapes or transcriptions. Numerical code will be used to identify data.

All documentation will be kept locked in a drawer in my residence for the duration of the research and afterwards be destroyed in a confidential manner (shredded).

The data will be kept under these secure conditions for no more than two years duration.

Computer files are protected by a password that only I have access to.

Confidentiality and anonymity can be assured in the individual interviews. It is possible that you may know other members of the focus group. It is not possible for me to guarantee that others in the group will not speak about the group experience outside of the group. However, I will be requesting that each girl avoid talking to others outside of the group about the group conversation.

Please be aware that if you disclose sensitive information that suggests harm to yourself, suicidal feeling or previous undeclared sexual abuse the study nurse has the legal responsibility to report this to the appropriate authorities.

It is anticipated that the results of this study will be shared with others in the following ways:

I will invite you to attend an informal discussion about the study results with members of the community. You are not required to attend this informal event.

I also will give you a written summary of the study results following completion of the study.
I also will be informing health care providers and researchers about the results at professional and community meetings.

I hope to submit the results to a peer reviewed academic journal such as the Canadian Journal of Nursing Research and will acknowledge the Tribal Council in the report.

- The data will be destroyed within two years.
- Relevant computer files will be deleted
- Hand written notes will be shredded when the project is completed, date to be within two years.

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researchers.

______________________________  _______________________  ________________
Name of Participant        Signature          Date

A copy of this consent will be left with you, and the researcher will take a copy.
APPENDIX D:

INFORMATION (ADVERTISING) POSTER

What Are Aboriginal Adolescent Mothers' Experiences of Postpartum Depression?

Seeking Adolescent moms with babies newborn to six months old

You are being invited to participate in a study entitled, "Adolescent Women's Postpartum Experiences in an Aboriginal Community" that is being conducted by Hazell Penn RN.

Could you spare 5 hours during April and May?

As a graduate student, Hazell Penn is required to conduct research as part of the requirements for a degree in Master's of Nursing. The research is being conducted under the supervision of Dr. Elizabeth Banister. You may contact her at 250-472-4703. You may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate Vice-President, Research at the University of Victoria (250-472-4545).

For more information leave your name and number at the Native Friendship Centre

Or call Hazell Penn at ____________
APPENDIX E:

INTERVIEW QUESTIONS FOR INDIVIDUAL INTERVIEWS

Questions for individual interviews are below. I will approach the interviews using these questions as a template and will engage the participant using a conversation style of interviewing (Kvale, 1996) There is a strong oral tradition in this community and I will listen attentively to their “stories” to discover what aspects of the interview are important to the interviewees.

Questions: I am interested in hearing about your experiences after having your baby. Can you tell me about this?

Some adolescent women have experiences of sadness after having had a baby. What was your experience after you had your baby?

I am wondering if you have experienced some sadness and if you can tell me more about this?

Can you describe any changes that took place in your life as a result of having had a baby? I am interested to know about the changes.

Can you tell me what those changes might look like during one of your typical days at this time?

I also asked for participants to describe the meaning of certain words and phrases they use in order to understand their experience more fully.

Probing questions will include: can you tell me more about that? Can you give me an example? Can you remember an occasion when you felt sad? Can you give me more detail about how you felt when that happened?

I will listen for content that sounds important for the participants while at the same time focusing on the research question under investigation. I may rephrase an answer to give clarification. Do you mean that . . . ?
APPENDIX F:

DEMOGRAPHIC FORM

Adolescent Girls’ Demographic Information

Initials please:

Date:

Location of Interview:

Age:

Current living arrangements:

Geographic area you were born in:

Where do you live now?

Length of time living here:

Marital status: (check one) Married ( ) Living common-law ( )

Separated ( ) Divorced ( ) Widowed ( )

Number of brothers and sisters and their ages:

Current school grade if you are away from school which grade were last in:

Which Band are you and your family from:

Do you have children? When were they born?

Age of current partner / boyfriend:

Your interests:

Goals:

Things you would like to do in the next 6 months:

In the next year:

Thank you for responding to these questions. Your identity will be kept confidential.