

Lived Experience of Postpartum Depression

The Lived Experience of Postpartum Depression as Reflected in Fabric Art

By

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B.A., University of Victoria, 1980
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ABSTRACT

Postpartum depression affects approximately 13% of women and negatively impacts their partners and children. This interpretive phenomenological study explored the lived experience of postpartum depression. Rich descriptions of four women's experiences were collected through conversational interviews, a focus group and fabric art. Three themes were identified: *cast adrift*, *torn asunder* and *safely home*. The findings suggested that women experience isolation, loss of identity and loss of sanity. Positive aspects of PPD were also revealed. Implications for nursing practice suggest increased targeted supportive programs for women shown to be at risk for PPD and increased support for all women and their families during the transition to parenthood. Recommendations for future nursing research include attention to fathers' postpartum experiences and the need for longitudinal studies of women's PPD experiences. Finally, nurse researchers are encouraged to use artwork as a source of rich data.

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Lived Experience of Postpartum Depression

“The art of qualitative research will illuminate the science of qualitative research and the science will give credence to the art”
(Whittemore, Chase, & Mandle, 2001, p. 523)

Chapter 1

Introduction

I have utilized phenomenological methodology to explore the lived experience of postpartum depression (PPD). More specifically, I was guided by Heidegger’s interpretivist approach or methodology to investigate this mental health phenomenon. My inquiry is fuelled by personal history of the illness, a desire to understand the essence of the experience and a need to provide an opportunity for women to share their experiences with others. PPD can be a debilitating illness that often surprises those who are affected by it; many women have told me that they never thought it would happen to them. Increased understanding of women’s experiences with PPD is important for professional nursing practice, for women’s health care providers, and as a strategy to raise public awareness of the devastating impact of this illness on new mothers and their families.

Statement of the Problem

PPD is a mental illness which affects approximately 13% of women in the first year after the birth of their infant (Abrams & Curran, 2007; O’Hara & Swain, 1996). Not only does it affect mothers but it contributes to negative outcomes for both their partners and children (BC Reproductive Mental Health, 2006; Beck, 1998; Goodman, 2004a;). Thus, a substantial percentage of the population is either directly or indirectly impacted.

Researchers have defined and quantified PPD, identified possible causes, and proposed preventative measures and treatment modalities (Beck, 1993; Beck, 2002; Boath, Bradley, & Anthony, 2004; Boath & Henshaw, 2001; Dennis & Hodnett, 2007;

Dennis & Creedy, 2006; Horowitz & Goodman, 2005). In addition, phenomenological research has investigated the lived experiences of women who have suffered from this condition (Beck, 1992).

A broad search in a variety of health related databases on “postpartum depression” results in over 5,000 studies. Despite this impressive amount of research, it is my experience working with postnatal women in Victoria, that this mental health issue is often under-recognized by women and their families. Lack of knowledge continues despite provision of educational materials through prenatal classes, maternity wards and public health. Most scientific research is published in professional journals using language that is inaccessible to the general public. The research filters through to the public eventually when it is the platform for development of programs such as those offered throughout the Vancouver Island Health Authority (BC Reproductive Mental Health Program & BC Ministry of Health, 2006). However, there is rarely a direct relationship between researchers and the general population.

I believe that one gap in PPD research is awareness of research knowledge by society in general. Public awareness about the phenomenon does not appear to be widespread, which is confirmed by the participants within my study. As many do not initially identify their experience as PPD, there is a resulting delay in treatment. How can nursing research contribute to an increased awareness and understanding of women’s experiences of PPD? How can women’s experience with the illness be more directly made visible with the population as a whole?

In this study, I investigated the lived experience of PPD and asked participants to create a visual representation of their experience. Through this research it is my intent to

both develop a greater understanding of the lived experience of the illness and provide an opportunity for women to share their knowledge through fabric art.

Background to the Study

Research indicates that approximately 13% of women become depressed in the postpartum period (Abrams & Curran, 2007; Beck, 1992; Beck, 1993; O'Hara & Swain, 1996). A qualitative systematic review by Dennis and Chung-Lee (2006) identified that, despite the high statistical incidence of PPD, there are numerous barriers to treatment. A noteworthy barrier addressed in the review is lack of awareness about PPD. An in-depth understanding of the illness is vital so that this knowledge can be disseminated to nurses, to other women's health care providers and to people living in our communities who could help identify and/or provide support/treatment for these women and their families. Nursing research can make an important contribution toward greater public awareness, appropriate support, and more timely treatment.

Theoretical Framework

Phenomenological methodology is utilized to investigate the lived experience of PPD. This approach is both a philosophy and an approach to research (Dowling, 2004; Dowling, 2007; Mackey, 2005; Wojner & Swanson, 2007). Its goal is to comprehend the lived experience of phenomena (Mapp, 2008; Mackey, 2005; Penner & McClement, 2008; van Manen, 1990; Wojner & Swanson, 2007). A phenomenon is opened up by attending carefully to the lived experience of individuals; to their experience of being-in-the-world. (Mapp, 2008; Cerbone, 2008).

Martin Heidegger's phenomenological philosophy was influenced by his teacher, Edmond Husserl (Wojnar & Swanson, 2007). Husserl is considered the founder of the

phenomenological approach to research and the developer of the descriptive paradigm. (Koch, 1995; Mapp, 2008). Husserl introduced the concept of the 'lived experience' to describe phenomena (Koch, 1995). His approach guides the researcher to 'bracket' his or her knowledge and biases about the phenomenon so as to not influence the research (Dowling, 2007; Mackey, 2005; Mapp, 2008). According to Husserl, the researcher engages in the work primarily to describe the phenomena (Koch, 1995). Heidegger differed from Husserl in believing that the lived experience needed to be an interpretive rather than a descriptive process (Dowling, 2007). The researcher's biases and assumptions are an integral part of this interpretive process and hence 'bracketing' is not a requirement (Crist & Tanner, 2003; de Witt & Ploeg, 2005; Lopez & Willis, 2004; Mapp, 2008; Penner & McClement, 2008).

Heidegger was a driving force of hermeneutic phenomenology (Annells, 1996). His interpretivist philosophy is ontological in focus. It is about understanding the concept of being-in-the-world, which Heidegger refers to as "Dasein" (Annells, 1996; Cerbone, 2008; Mackey, 2005), the idea that individuals are ontologically in and of themselves, or in essence, a holistic nature of being (Cerbone, 2008). I have come to view Dasein as a way of referring to the 'essentialness' of who we are, the fundamental, infinitesimally small atomic particle that is our pure and true being which encapsulates who we are as individuals. "An essential feature of Dasein is that this is an entity which to each of us is ourself and includes inquiring as one of the possibilities of our being" (Annells, 1996, p. 706). The goal, therefore, of hermeneutic phenomenology is understanding the essence of the lived experiences or "the human way of being in the world" (Wojnar & Swanson, 2007, p.174)

Heidegger believed that the researcher should bring his/her own knowledge, understanding, history, insights and biases to the research process (Crist & Tanner, 2003; de Witt & Ploeg, 2005; Mapp, 2008; Penner & McClement, 2008). The researcher's personal and intuitive knowledge is valued in the interpretive approach and is regarded as an asset rather than a liability or something that needs to be set aside and bracketed (Lopez & Willis, 2004). "Heidegger referred to this process as entering into a hermeneutic circle of understanding that reveals a blending of meanings as articulated by the researcher and the participants" (Wojnar & Swanson, 2007, p. 175). Interpretive phenomenology is a partnership of participant and researcher working to understanding the essence of a phenomenon.

Heidegger's interpretive approach is the framework that guided my study whose goal is to explore and interpret the experience of four women self identified as having PPD in the past. As recommended by the interpretive approach, I bring to this research my personal experience of postpartum depression 24 years ago. I also include the knowledge, beliefs, and assumptions I make based on my experiences as a public health nurse who has worked with depressed postpartum women for 10 years. With these attributes I will fully engage with the participants to "gain deeper insights through the informant's and investigator's co-creation of substantive findings" (Crist, 2003, p. 203). The essence of the PPD depression will be revealed through this creative and interpretive process.

Heidegger's ontological perspective guides me to understand the essential nature (van Manen, 1990) of postpartum depression or, the being-in-the world of a woman who had postpartum depression. The theoretical framework is congruent with my own world

view in that I believe that there are multiple realities and each person's reality is a unique meshing of their experience and world view. Their reality, then, is that essential Dasein of their being so one cannot appreciate a particular phenomenon without first fully exploring what it means for the person experiencing it. In order to understand the essence of women's experience I also believe it is helpful for the researcher to have insider knowledge of the phenomena. My experience with PPD will not mirror the experience of the participants, but it will contribute to the interpretation. My values and beliefs are well supported by the essential elements of Heidegger's interpretivist philosophy.

Specific Problem and Research Question

Approximately 13% of postpartum women worldwide experience postpartum depression (O'Hara & Swain, 1996). The preponderance of postpartum depression research has been constructed from a biomedical perspective and discusses the prevalence, cause, effects, prevention and treatment of postpartum depression (Beck, 2008; Dennis & Chung-Lee, 2006; Dennis & Creedy, 2004; Dennis & Hodnett, 2007). Few frame the research in a way that captures women's own voices and interpretations of their lived experiences. In order to address this gap in the research, I used an interpretive phenomenological methodology to explore the question; "what is the lived experience of women who have experienced postpartum depression". This research approach helped to capture contextual and rich descriptions of the complex meanings of this phenomenon.

Overview of Methodology

The goal of interpretative phenomenology is to understand the lived experience of a phenomenon (Penner & McClement, 2008, Wojner & Swanson, 2007). The researcher and the participant each bring his or her own history, culture, biases and assumptions to

the research (Dowling, 2004; Mapp, 2008; Penner & McClement, 2008; Wojner & Swanson, 2007). They engage in dialogue to explore interpretations of the lived experience (Penner & McClement, 2008; Wojner & Swanson, 2007). As they discuss the phenomenon in question they enter into a relationship wherein understandings are questioned, modified and re-examined. This circular process is referred to as the hermeneutic circle.

Purposive sampling techniques (Mapp, 2008) led to the recruitment of four women who self identified as having a history of postpartum depression. Data was obtained through one conversational interview with each woman, in addition to one follow-up focus group discussion attended by three of the four participants. Participants were also invited to create a visual representation of their postpartum experience and this representation of their experience provided a stimulus for meaningful conversations and deeper reflection.

The individual and focus group conversations were audio-taped and subsequently transcribed verbatim. The audio-tapes were listened to numerous times. The transcribed interviews were read carefully for patterns, ideas and hunches about each woman's experience. The artwork was also examined for patterns and ideas. Emergent ideas gradually coalesced into themes (van Manen, 1990). This process was one of "insightful invention" (van Manen, 1990, p. 79) to come to an ever-deeper understanding of the lived experience of postpartum depression as expressed by each participant. Researcher insights, questions and initial hunches were written in a notebook and, as transcription progressed, notes were also made on the backs and margins of the transcribed interview pages (Love, 1994). Each theme was demonstrated by highlighting a paradigm case,

which is a rich description of a particular pattern of meaning, and exemplars were then identified to illustrate the themes (Crist & Tanner, 2003; Leonard, 1994). Three themes emerged from the data; 1) cast adrift, 2) torn asunder, and 3) safely home.

Standpoint

My standpoint is as follows:

1. All postnatal women are at risk of developing PPD.
2. Life partners, both male and female, of women with PPD can also develop PPD.
3. Psychosocial risk factors are as great an influence as biomedical factors.
4. Artwork can eloquently represent a person's experience and provide an opening for deeper understanding.
5. The creation and display of artwork can elevate public awareness.
6. Women's memories of impactful experiences do not fade with time.

Structure of the Thesis

This thesis is divided into five chapters. Chapter one outlines the issues surrounding postpartum depression and how my research will add to the understanding of this illness experience. It also explicates the theoretical framework that grounds this research and the approach to data collection and analysis. Chapter two is a review of the literature about postpartum depression identifying what is known about this phenomenon broadly. Chapter three describes the methods for data collection and analysis. Chapter four describes the data and my findings. Chapter five summarizes the findings and identifies/discusses the implications of the study for nursing practice and for future research.

CHAPTER 2

Review of the Literature

Introduction

I conducted this review of research literature regarding postpartum depression (PPD) to examine existing knowledge and identify research gaps. As a nurse I wanted to make a contribution to disciplinary knowledge about women's experience with PPD and to identify the implications for nursing practice and future research. The studies cited provide a comprehensive overview of this mental health phenomenon. They also build a foundational context about PPD so that the results of my work have greater resonance. To provide this context, I first looked at theories about the transition to motherhood. I then examined material about PPD from three perspectives, namely, that which: a) investigated elements of the illness; b) discussed its incidence, prevention, treatment, risk factors and symptomatology; c) considered its impact on women, their children and partners.

Transition to Motherhood

The transition to new motherhood, whether or not a woman has PPD, is an enormous challenge. This time in a woman's life is characterized by loss, profound change, fatigue and isolation (Rogan, Shmied, Barclay, Everitt, & Wyllie, 1997). In a grounded theory study nurse researchers Barclay, Everitt, Rogan, Schmied and Wyllie (1997) investigated normal transition to motherhood because "unless 'normal' was understood it was impossible to recognize or manage the problems that women face at either a therapeutic or social level" (p. 720). They suggested a conceptualization of early motherhood summarized by six categories: 'realizing', 'unready', 'drained', 'aloneness',

'loss', and 'working it out' that contribute to the core category of 'becoming a mother'. Barclay et al. revealed that women experienced a profound metamorphosis of their self-concept; they transitioned from a clear concept of self in a known world to an unclear concept of self in an unknown world. The researchers proposed three mediating factors affecting the transition in becoming a mother. First was the personality of the baby and the mother's reactions to the baby. Second was the mother's personal history with infants such as babysitting or contact with babies of family or friends. The last factor was the availability of social support. This last factor has implications for nursing and the support nurses can offer new mothers to ease the transition into motherhood.

In her synthesis of past and present nursing research, Mercer (2004) proposed that the period of transition usually referred to as maternal role attainment, should be renamed 'becoming a mother' (BAM). Four stages for becoming a mother were suggested: 1) commitment, attachment and preparation in pregnancy; 2) acquaintance, learning, and physical restoration in the first two to six weeks following birth; 3) moving forward to a new normal in the two weeks to four months following birth; 4) achievement of maternal identity at approximately four months following birth. Positive adaptation to motherhood began with the mother's commitment and preparation in pregnancy. Within the first six weeks of the birth she became acquainted with her newborn, learned the nuances of her infant's cues and gradually discovered effective responses. Life with the baby slowly became normal, and the mother made adjustments in response to her changing relationships with family and friends. Finally, she achieved maternal identity feeling confident and competent in her new role. Transformation of self was complete and she

had become a mother. The stages overlapped one another and their length was influenced by maternal, infant, family and environmental factors.

Three environments affected the transition in becoming a mother (Mercer, 2007). Immediate family and friends formed the innermost environment and their support, stressors, values and cultural norms were influences within this sphere. Family and friends were contained within the community environment that provided health care, recreation, employment and protection. The community environment was contained within society at large, which was responsible for providing laws and cultural consistencies. Factors within these three environmental levels influenced women's transitions to motherhood.

A conceptual framework of loss was utilized to provide understanding for the transition to becoming a mother (Barclay & Lloyd, 1996). The birth of the baby forced the mother to let go of a long held view of the world and replace it with another. While slowly taking on the role of the mother and learning to take care of the baby, the woman also had to let go of parts of her former identity that were incompatible with her new role. In addition, many women had to lower their expectations of parenthood and come to terms with the fact that quality of life may be diminished by the birth of the baby. Loss of identity and expectations were identified as elements of transition to motherhood.

Nursing research has identified that the transition to motherhood is challenging for many women. The challenge increases when a woman is struggling with PPD in addition to the normal transition of becoming a mother.

Definition of Postpartum Depression

PPD is a non-psychotic depressive disorder experienced by approximately 10% to 26% of women worldwide (Baker, 2002; Horowitz & Cousins, 2006; O'Hara & Swain, 1996; Williamson, 2007). Although defined as beginning within the first four weeks after giving birth (American Psychiatric Association, 2000), many researchers and health professionals agree that onset can occur at any time within the first year of the infant's life (Davies, Howells & Jenkins, 2003; O'Hara & Swain, 1996; Perry, 2008; Ugarriza, & Schmidt, 2006). It can progress over months and, left untreated, may develop into a chronic mental illness (Goodman, 2004b).

PPD's psychiatric diagnosis requires the presence of five or more of the following symptoms for a minimum of two weeks: insomnia or extreme sleepiness, psychomotor agitation or retardation, fatigue, changes in appetite, feelings of worthlessness or guilt, decreased concentration, and suicidal ideation. Additionally, the woman must experience either depressed mood and/or a loss of interest or pleasure (American Psychiatric Association, 2000; Flynn, 2005). She may confuse these symptoms with what she assumes is a normal, albeit unpleasant, transition into motherhood (Hanna, Jarman & Savage, 2004) so the number of women suffering from PPD may well be underestimated (Hanna et al., 2004).

It is evident that PPD is a phenomenon affecting a remarkable number of women throughout the world. Researchers have identified risk factors that identify women at increased risk of developing the illness. If health professionals can identify vulnerable women, they may be able to either prevent the depression's onset or provide early treatment.

Symptomatology

The range of underlying factors in PPD leads to a variety of problematic symptoms for those affected. Psychiatric definition and classification cannot portray the emotional and physical distress that many women suffer. Whatever the cause, be it biological, psychosocial or unknown, their anguish is irrefutable.

Researchers recorded a wide range of troublesome emotional feelings experienced by women suffering from postpartum depression. Women reported feeling anxious, overwhelmed and inadequate (Beck, 2005; Hanley, 2006; McIntosh, 1993; Williamson & McCutcheon, 2007). Some felt unable to cope with the demands of their infant, and then experienced guilt for not living up to the ideal image of a capable mother (Urgarriza & Schmidt, 2006). Many described poor or impaired concentration. (Beck, 2005; Flynn, 2005; Hanley, 2006; Williamson & McCutcheon, 2007). Tearfulness and loss of interest in pleasurable activities were also present (Flynn, 2005; Hanley, 2006; McIntosh, 1993; Morrow, Smith, Lai, & Jaswal, 2008; Urgarriza & Schmidt, 2006).

Changes in Sleeping and Eating Habits

Alterations in daily life patterns were commonly mentioned symptoms of PPD. Needing to feed the infant regularly meant that the mother's rest was frequently interrupted, and she may have had trouble falling asleep even when her infant was sleeping. Such disturbances led to chronic fatigue (Hanley, 2006; McIntosh, 1993; Williamson & McCutcheon, 2007) and irritability (Beck, 2005). Conversely, a woman may have felt intensely sleepy and had difficulty getting out of bed. (Davies et al., 2003; Flynn, 2005; McIntosh, 1993).

Changes in eating habits were noted in women with PPD. These changes led to anorexia and accompanying weight loss or the opposite: overeating and accompanying weight gain (Hanley, 2006).

Relationship Disturbances

Relationship disturbances between infant and mother were identified as a result of postpartum depression (Baker et al., 2002; Williamson & McCutcheon, 2007). A mother may lose all interest in her infant and have trouble taking care of the infant's needs. Another may become overly concerned and attentive, worrying continuously that something is wrong with the infant. In severe cases, some experienced thoughts of harming the infant. These are terrifying episodes that were very rarely acted upon (Baker et al., 2002).

Symptoms of PPD ranged from mildly bothersome to terrifying. They may be particularly intense in a woman who, before childbirth, was self-assured and highly functioning. Researchers noted that these women experienced a loss of self; the person they were before the birth had dissolved into someone who struggled to deal with the most mundane tasks (Beck, 2005). In summary, the symptoms of PPD can have an overwhelming, detrimental impact on women's experience of motherhood.

Impact on the Family

Postpartum depression had an adverse impact, not only for women enduring it, but also for their partners and children. Researchers found that the effect of this depression could be momentous and long lasting.

*Impact on Women**Breastfeeding*

The World Health Organization (WHO, 1989) strongly encourages women to breastfeed their infants. Breastmilk “provides nutritional, immunological, and emotional nurturing for normal growth and development during the vulnerable first years of a child’s life” (Breastfeeding Committee for Canada, n.d.). Studies of breastfeeding practices in postpartum depressed women suggested that PPD negatively impacted this choice (Hatton et al., 2005; Henderson, Evans, Straton, Priest, & Hagan, 2003). Hatton et al. found that those with depressive symptoms at six weeks postpartum were less likely to breastfeed than non-depressed women. Additionally, Henderson et al. discovered that postpartum depressed women stopped breastfeeding significantly earlier than women who were not depressed. In summary, postpartum depression interfered with a woman’s ability to provide optimal nutritional requirements through breastfeeding.

Daily Functioning and Self-Care

Women with PPD also demonstrated lower personal, household, social, and childcare functioning (Posmontier, 2008). These indicators made the accomplishment of everyday activities particularly challenging, with potential far-reaching undesirable effects on ability to sustain family income, social networking, and health maintenance.

Researchers appeared divided about the childcare ability of postpartum depressed women. Posmontier (2008) concluded that a woman’s physical care of her infant was not affected; indeed, such care – though more robotic and less nurturing (Beck, 1996) – may have taken precedence to the detriment of other tasks. Conversely, women in Edwards and Timmons’ (2005) study recounted problems in basic infant care tasks such as feeding,

bathing and changing diapers. Despite differences in research studies, considerable evidence suggested that daily functioning of women with PPD was adversely affected.

It is not surprising that PPD may have also interfered with a woman's ability to take care of herself, and seek, or follow through on, treatment (Horowitz and Cousins, 2006). Their study showed very low medication or psychotherapeutic rates for treatment of PPD, concluding that women enduring the depression did not self-report, choosing to isolate and protect themselves instead. Women may not have recognized their symptoms as depression (Baker et al., 2002; Dennis & Ross, 2006; Ugarizza & Schmidt, 2006), so did not seek help for how they were feeling.

Suicide

Postpartum depression may have even more serious consequences for women. The risk of suicide has been identified as the most common cause of indirect maternal mortality in Australia and the United Kingdom (King, Slaytor, & Sullivan, 2004; Ratnaike, 2006). While researchers have indicated that pregnancy and the first year postpartum conferred some protection against taking one's life (Appleby, 1991), women who did this, tended to do so within the first three months postpartum (Ratnaike, 2006). PPD not only impaired women's daily functioning, it threatened their very existence.

Impact on Women's Partners

PPD has been shown to have a detrimental affect not only on the mother, but also on her partner. Incidence of depression in men in general was 1.2% to 25.5%, while in those whose partners have PPD it was 24% to 50% (Goodman, 2004a). This strong correlation expressed the harmful results of PPD on family functioning and well-being. One postulation was that witnessing the suffering of the mother had a dramatic effect on

the partner. The marital relationship was put at increased risk (Boath, Pryce, & Cox, 1998), as neither person could support the other during this stressful time.

Impact on Children of Affected Parents

One of the most devastating impacts of PPD was the effect on the children of depressed mothers. As noted above, there was much evidence that PPD hinders mother-infant interaction (Baker et al., 2002; Beck, 1995; Dennis & Chung-Lee, 2006; Hanley, 2006; Murray & Cooper, 1996; Murray, Cooper, Wilson, & Romaniuk, 2003; Stanley et al., 2004). The infant learns about the world through interactions with the parent (Beck, 1995). When the depressed parent could not see or respond to the infant's cues, the synchronicity of parent-infant interaction was disrupted. The infant may have then become confused, disoriented and unsure how to respond to the despondent caregiver (Hanley, 2006).

Infants of women with PPD displayed a range of unwanted outcomes (e.g., a high rate of insecure attachment) primarily due to disrupted maternal-infant interaction (Edhborg, Lundh, Seimyr, & Widstrom, 2001; McMahon et al., 2006; Murray, 1992; Murray & Cooper, 1996; Stanley et al., 2004). Poor cognitive functioning was also documented, as well as setbacks in behavioural and emotional adjustment (Horowitz & Cousins, 2006; Murray & Cooper, 1996; Stanley et al., 2004). Affected infants displayed sleep disturbances, temper tantrums, eating difficulties and excessive dependency (Murray, 1992).

The discernable adverse impact of PPD on infants may continue into their early childhood. Boys showed more attention-deficit type behaviours, while girls were more withdrawn and anxious (Buist, 2006). Cognitive development of boys, in particular,

continued to be delayed into their childhood (Murray & Cooper, 1996; Hanley, 2006). Eighteen-month-old toddlers appeared less securely attached to their depressed mothers than children of non-depressed mothers, with boys again more affected than girls (Murray, 1992). Children of postpartum depressed mothers were documented as having a less playful and joyful relationship with their mothers, evidence that they were injuriously affected by their mother's condition.

Risk Factors

Various factors that put women at risk for PPD have been extensively studied. Because PPD may result from a variety of inter-related causes, it is difficult to single out a specific, individual risk factor. Both biomedical and psychosocial influences were investigated in this literature review.

Biomedical Risk Factors

Researchers have studied the influence of biomedical risk factors on the development of PPD. Four risk factors most often noted were hormone levels, anemia, hypothyroid dysfunction and the proinflammatory response.

Hormone Level

Researchers suggested that some women may be at higher risk for PPD due to their sensitivity to postpartum estrogen and progesterone levels (Bloch, Schmidt, Danaceau, Murphy, & Nieman, 2000). Also of interest is that low progesterone levels in the early postpartum period have been associated with PPD six months after childbirth (Ingram, Greenwood, & Woolridge, 2003). Thus, hormone levels may be a factor in the development of PPD.

Anemia

In addition to the influence of hormone levels on PPD, anemia has also been shown to play a role. Anemia results when hemoglobin concentration of the blood is low and can be caused by iron deficiency. Symptoms include apathy, irritability and difficulty concentrating (Corwin & Arbour, 2007) - symptoms all commonly associated with postpartum depression (Beck & Indman, 2005). Many women are iron deficient throughout pregnancy and, despite recommendations for prenatal iron supplements, compliance is generally low. Hemoglobin levels drop further with blood loss in childbirth (Corwin & Arbour, 2007). Therefore, when many women are anemic postpartum their symptoms may be ascribed to, or exacerbate, depression.

Thyroid Dysfunction

Thyroid dysfunction is another biological factor that may contribute to postpartum depression. Both auto-antibody and thyroid-stimulating hormone levels increase when the thyroid is not functioning normally. Researchers have shown that the presence of thyroid auto-antibodies or a high thyroid-stimulating hormone (TSH) level is related to symptoms of depression (McCoy, Beal, Payton, Stewart, DeMers, & Watson, 2008). In addition, between 1.1% and 16.7% of postnatal women develop postpartum thyroiditis, which begins with hyperthyroidism and evolves into hypothyroidism by 19 weeks postpartum, usually resolving within a year (Corwin & Arbour, 2007). Hypothyroidism allows auto-antibody and TSH levels to increase, possibly escalating depressive symptoms. Consequently, a sizeable number of women affected by thyroid dysfunction may have this factor in the development of PPD.

Proinflammatory Response

Recently, the role of the proinflammatory response on PPD has been considered (Corwin, Johnston & Pugh, 2008). After researchers discovered a relationship between increased proinflammatory cytokines and depression in the general population (Corwin et al., 2008), they hypothesized that this may also be noteworthy for the onset of postpartum depression. Childbirth results in a maternal proinflammatory response caused by perineal tissue damage in addition to the pain, physical exertion and stress of labour. Postpartum infections, such endometritis, urinary tract infections and mastitis, can also trigger this response (Corwin & Arbour, 2007), resulting in elevated levels of proinflammatory cytokines. These researchers found a positive correlation between increased proinflammatory cytokines and development of postpartum depression, indicating that physical damage caused by giving birth, combined with postpartum infections, can affect this illness.

Psychosocial Risk Factors

There are many psychosocial factors underlying the development of postpartum depression. As very few exist in isolation, many researchers proposed that a variety of these factors created a unique set of circumstances for each woman affected by the depression. No single cause has been identified (Baker et al., 2002); each is part of a patchwork quilt of possible causes.

Previous Depression

One of the strongest contributing factors for this depression is previous history of depression or psychological disturbance. (Baker et al., 2002; Beck, 2001; O'Hara & Swain, 1996; Robertson, Grace, Wallington, & Stewart, 2004).

Women who experienced postpartum depression with a previous pregnancy have 30% to 50% likelihood of reoccurrence (Baker et al., 2002). However, personal history of depressive illness at any time puts a woman at substantial risk postpartum (Hanley, 2006; Robertson et al., 2002). Depression in a woman's family of origin may also abet development of postpartum depression (Baker et al., 2002; Robertson et al., 2002).

Social Factors

Researchers identified many social factors as possibly augmenting development of postpartum depression. These included isolation, inadequate social support, childcare stress, prenatal anxiety, relationship challenges between the mother and partner, experience of stressful life events in pregnancy or postpartum, history of sexual abuse, and exposure to poor maternal role models (Baker et al., 2002; Beck, 2001; Hanley, 2006; Horowitz & Goodman, 2005; O'Hara & Swain, 1996; Robertson et al. 2002). Again, no particular one was predominant, so exact etiology of PPD remains a mystery. It is evident, however, that both biomedical and psychosocial factors are involved.

Early Identification

Many researchers advocated early identification of postpartum depression indicators in pregnancy to instigate early education strategies (Beck, 1998; Dennis & Ross, 2006; Ogrodniczuk & Piper, 2003; Zlotnick, Miller, Pearlstein, Howard, & Sweeney, 2006). They proposed brief group Interpersonal Therapy (IPT) sessions to educate women about PPD, role transitions, developing support systems and understanding interpersonal conflicts. "A minimal level of preventive care should include education about postnatal depression, close monitoring of symptomatology and

functioning, and a clear plan for early treatment should the woman go to develop postnatal depression” (Ogrodniczuk & Piper, 2003, p. 302).

Screening for Postpartum Depression

Early identification of risk for PPD is essential for its prevention and averting its distressing effects for everyone in the family (Hanna et al., 2004). Up to 50% of cases may be undetected (Beck & Gable, 2001) so universal screening is a critical strategy. Screening in both antenatal and postpartum periods was helpful in recognizing women at risk for PPD or who were already experiencing it (Buist et al., 2002). Early treatment options may then be offered to prevent the depression worsening. The screening itself is an effective tactic to increase women’s awareness of the condition.

Edinburgh Postnatal Depression Scale

The most widely used screening tool is the Edinburgh Postnatal Depression Scale (EPDS) (Cox, Holden & Sagovsky, 1987), a ten item self-report questionnaire. Each question has four possible responses from “no, not at all” to “yes, most of the time”; negative responses are scored zero to a range of three for the most positive response, resulting in a score range of zero to 30. Cox et al. (1987) reported a sensitivity of 86%, specificity of 78% and a positive predictive value of 73%. The score reflects the woman’s experience in the previous seven days. The EPDS has been validated in pregnancy, the postpartum period, and also for fathers (Beck & Gable, 2001). The British Columbia government has incorporated it into the antenatal record physicians and midwives use to record patient prenatal care. Recommendations advise that screening be offered between 28 and 32 weeks gestation (BC Reproductive Mental Health Program & BC Ministry of Health, 2006).

Postpartum Depression Screening Scale

Another common screening tool is the Postpartum Depression Screening Scale (PDSS) (Beck & Gable, 2000), a questionnaire with 35 items in a five-point Likert scale. Questions reflect seven aspects of PPD, each with five questions: sleeping/eating disturbances, anxiety/insecurity, emotional lability, cognitive impairment, loss of self, guilt/shame, and contemplating harming oneself. The response scale varies from one, “strongly disagree” to five, “strongly agree”. The score is a reflection of the woman’s experience within the previous two weeks. Alpha reliability of the seven aspects ranges from 83% to 94%.

Postpartum depression screening is a vital first step in its diagnosis and prevention. Researchers found that women do not necessarily identify depression as the first or most important symptom of PPD. Instead, they identified individual symptoms such as anxiety, insomnia, confusion, irritability and agitation before depression (Beck & Gable, 2001). Screening for PPD recognizes women at risk, singling out individual symptoms before the woman’s experience becomes more critical. Preventative strategies can then be put in place or treatment initiated.

Nursing Interventions

Early Education

Early education about the postpartum period had been explored in childbirth preparation classes (Matthey, Kavanagh, Howie, Barnett, & Charles, 2004). An intervention session was added to the regular curriculum so couples could discuss any psychosocial concerns they had and try problem solving exercises. Discussions took place in single-gender groups and mixed-gender groups. Follow-up information was

mailed to the couples afterwards and again one to two weeks after the birth of their infant. This was moderately successful; women with low self-esteem reported elevated mood and sense of confidence at six weeks postpartum in comparison to women who did not receive the intervention. Partners showed greater awareness of the mothers' experience. However, by six months postpartum, there were no discernable differences between the parents who had received the intervention and those who had not. Short term success was achieved, but not provision of long term protection from the depression.

Debriefing Strategies

Further preventative strategies involved opportunities for women to debrief about their experiences in the immediate postpartum period. Researchers recommended that midwives and nurses allow time in the maternity ward for women to discuss their birth experience (Ogrodniczuk & Piper, 2003). Researchers also suggested regular visits by nurses in the first six months postpartum. (Dennis & Creedy, 2004; Ogrodniczuk & Piper, 2003). These visits supported the women's transition into their new role and provided ongoing opportunities for them to talk through the challenges they were experiencing.

Target Risk Factors

Prevention strategies focused on addressing particular risk factors for PPD development, such as infant sleep patterns. It was acknowledged that infant sleep patterns were a cause of maternal fatigue, and strongly associated with the onset of postpartum depression (Dennis & Ross, 2005). Behavioural strategies that addressed persistent infant sleep problems were explored, with some success (Hiscock, Bayer, Hampton, Ukoumunne, & Wake, 2008). Nurses provided education and guidance to families who self-identified as having an infant with sleep problems. Strategies involved gradually

increasing the length of time between responding to the infant or gradually decreasing the length of time spent sitting with the infant while the infant fell asleep. At two years, mothers in the study were less likely to report symptoms of depression. “Managing infant sleep represents a feasible, acceptable, low-intensity, and cost-effective preventive intervention approach for maternal depression” (Hiscock et al., 2008, p. e621).

Dennis and Creedy (2004) investigated psychosocial and psychological interventions for the prevention of postpartum depression. They reviewed fifteen trials reported between 1995 and 2003, involving 7,697 women in total and concluded that women who received preventative intervention were just as likely to develop postpartum depression as women who received no interventions. However, they also concluded that home visits by nurses showed promise in the prevention of this condition.

Prevention of PPD remains a challenge. Research was inconclusive regarding specific prevention strategies but it seemed that simple, supportive care was at least as effective as any more complex treatments.

Treatment

Treatment modalities of PPD addressed its biomedical and psychosocial influences, ranging from very straightforward strategies to complex combinations of medication and psychotherapy. These options must also be considered in light of the woman’s individual needs, resources and acceptance of treatment. Researchers identified a number of treatment modalities but there was little agreement about the most effective option. Just as PPD does not have a single etiology, a single treatment modality has not been determined (Dennis & Hodnett, 2007).

The world view of the health professional also influenced the women's choice of treatment (Beck, 2002). One may favour pharmacological treatment, believing the primary cause of PPD to be biomedical. Another believing the primary cause to be psychosocial in origin may favour non-pharmacological treatment such as support group referral. In either case, women benefited by timely and appropriate treatment (Baker et al., 2002; Hanley, 2006) based on severity of symptoms, the woman's acceptance of the particular treatment and availability of local services (McQueen et al., 2008).

Pharmacological Therapy

Selective Serotonin Reuptake Inhibitor Medication

Pharmacological therapy in the form of antidepressant medication was identified as an effective treatment for postpartum depression (Buist, 2006; Davies et al., 2003; Grigoriadis & Ravitz, 2007; Hanley, 2006; Horowitz & Goodman, 2005; Ugarizza & Schmidt, 2006). Selective serotonin reuptake inhibitors (SSRI) were the most commonly prescribed antidepressants (Ugarizza & Schmidt, 2006) and were most often used when the depression was severe or unresponsive to non-pharmacological treatments (Buist, 2006).

Many breastfeeding women avoided use of pharmacological therapy with SSRI for fear that it would affect their milk supply or expose the infant to risk from the medication (Grigoriadis & Ravitz, 2007; McQueen, Montgomery, Lappan-Gracon, Evans & Hunter, 2008 O'Hara, Stuart, Gorman, & Wenzel, 2000). In fact, there was little scientific evidence regarding the development of children exposed to antidepressant medication through breastmilk (Pearlstein, 2008). The risk of antidepressant medication to both mother and infant must be considered in relation to the risk of not adequately

treating the illness, thus exposing the infant to the long-term impact of the mother's depression (Misri & Kendrick, 2007). A careful and comprehensive evaluation of maternal and infant risk must be undertaken to decide if pharmacological or non-pharmacological treatment is the more appropriate for the individual mother.

Anti-Inflammatory Medication

The use of anti-inflammatory medication was another form of pharmacological therapy in treating PPD. It was used in response to research suggesting that an increase in proinflammatory cytokine increased a woman's risk of incurring this depression (Corwin & Johnston, 2008). A decrease in proinflammatory cytokines was accomplished through the use of non-steroidal anti-inflammatory medications in addition to early treatment of perinatal infections and meticulous wound care (Corwin & Johnston, 2008).

Hormone Therapy

Hormone therapy has also been proposed for the treatment of PPD addressing the theory that hormone imbalance is a contributing factor. There was little research to show that hormone therapy was effective. Estrogen therapy has been shown to be of modest value, but further research is needed (Dennis, Ross, & Herxheimer, 2008).

Non-Pharmacological Therapy

Non-pharmacological therapies have successfully treated postpartum depression. Examples are Cognitive-Behavioural Therapy (CBT), Interpersonal Psychotherapy (IPT), counseling, listening visits and general support.

Cognitive-Behavioural Therapy

Cognitive-Behavioural Therapy (CBT) is a psychological treatment that addresses the interaction between thinking, feeling and behaving (Somers, 2007). A person's

thoughts affect how he or she feels, which in turn affect his or her behavior. Therefore, cognitive distortions, or thoughts that have no basis in reality, can incite negative emotions. CBT helps women recognize cognitive distortions and encourages thoughts that support a more realistic assessment of the situation.

CBT has been demonstrated as a successful treatment for non-psychotic PPD (Corral, Kostaras, & Kuan, 2005; Hanley, 2006; Highet & Drummond, 2004; Milgrom, Negri, Gemmill, McNeil, & Martin, 2005). It was shown to be as effective as antidepressant medication for treatment of mild to moderate depression (Highet & Drummond, 2004). The efficacy of both group and individual CBT was also investigated (Highet & Drummond, 2004; Milgrom et al., 2005). Highet and Drummond found that individual CBT treatment led to immediate positive outcomes, but by six months post treatment, all women benefited from the treatment regardless of delivery method. Milgrom et al. suggested that individual CBT was probably more effective than group CBT in that their study demonstrated individual counseling was more effective than group counseling. Essentially, both group and individual CBT demonstrated efficacy in PPD treatment.

Interpersonal Psychotherapy

Interpersonal Psychotherapy (IPT) was another successful non-pharmacological option for the treatment of PPD (Buist, 2006; Corral, Kostaras & Kuan, 2005; Grigoriadis & Ravitz, 2007; Horowitz & Goodman, 2005; McQueen, Montgomery, Lappan-Gracon, Evans, & Hunter, 2008; O'Hara, Stuart, Gorman, & Wenzel, 2000; Reay, Fisher, Robertson, Adams, & Owen, 2006). Interpersonal Psychotherapy, as the name suggests, concentrates on interpersonal challenges that can detrimentally affect relationships.

Contributing social factors to PPD often involved role transitions and challenging interpersonal relationships between partners and/or extended family (Corral et al., 2005; Grigoriadis & Ravitz, 2007; O'Hara et al., 2000). Therapists using IPT focused on social factors that contributed to evolution of PPD and encouraged women to work through interpersonal problems (Grigoriadis & Ravitz, 2007). In addition to decreasing symptoms of postpartum depression, IPT has been shown to improve social adjustment (O'Hara et al., 2000). IPT also had long-term positive outcomes in PPD treatment (Reay et al., 2006) and both individual and group therapy sessions were equally successful treatment options (O'Hara et al., 2000; Reay et al., 2006). IPT offered a problem-orientated, short term, effective treatment for postpartum depression.

Non-Directive Counselling

Non-directive counselling was also identified as an effective treatment for mild to moderate PPD (Perry, 2008). Hight and Drummond (2004) stated that it was as effective as CBT, while Milgrom et al. (2005) suggested that individual non-directive counseling was even marginally more effective than CBT. Nurse researchers have referred to non-directive counselling as 'listening visits' (Davies et al., 2003), and have suggested that these visits were a cost effective, efficient form of treatment for postpartum depression. Public health nurses who visit women in the early postpartum period could offer this form of support (Murray et al., 2003). It is essential that women with PPD have an opportunity to share their thoughts and feelings with a non-judgmental, empathetic health professional who clearly understands the issue (Buist, 2006; Dennis & Chung-Lee, 2006; Hanley, 2006).

Non-directive counselling has also been offered via the telephone (Dennis, 2003; Urganizza & Schmidt, 2006). The work and inconvenience of organizing herself and her infant to leave home for a psychotherapeutic appointment may be an insurmountable barrier for some depressed women. Telephone support allowed the woman to receive supportive counseling at home, avoiding the additional stresses and anxiety of getting ready, travelling, possible expense and need to arrange childcare.

Support Groups

Nurse researchers have identified that basic caring social interactions with peers are often effective non-pharmacological treatments for PPD. Support groups have been shown to be effective whether or not the support group's primary focus is PPD (McQueen et al., 2008). Mother/baby and exercising get-togethers helped decrease depression symptomatology (Heh, Huang, Ho, Fu, & Wang, 2008). Social connection and support was crucial in the postpartum period as it assisted a woman's transition into the motherhood role, with the added benefit of not labeling her with a mental health illness (Flynn, 2005). Attendance at these groups was "non-labeling" and more socially acceptable for some women.

Nutrition

Recent postpartum depression treatment research has looked into the role of nutrition in treatment, specifically, the efficacy of omega-3 fatty acids (Freeman, 2009; Rees, Austin, & Parker, 2008). To date, no placebo-controlled trials have confirmed their success for this purpose. Further research has been proposed (Freeman, 2009; Rees, Austin, & Parker, 2008)

Women's Experiences of Postpartum Depression

Qualitative research approaches have contributed to our understanding of women's experiences with the phenomenon of PPD. This literature review will examine a sampling of reported qualitative research studies in order to offer a more contextualized in-depth description of women's experiences with this depression. These methodologies explore the essence of PPD from the woman's perspective; it is not research about an aspect of the illness, but rather, research that partners with women to understand their experience.

Nursing studies of postpartum depression have been undertaken using an ethnographic approach with first generation Punjabi-speaking, Cantonese-speaking and Mandarin-speaking immigrant women (Morrow, Smith, Lai, & Jaswal, 2008). An examination of the participants' narratives provided researchers with a better understanding of women's experiences in similar circumstances and the services that are most beneficial to their recovery. Researchers found that the stresses adjusting to a new country contributed to development of PPD. In addition, positive and negative interpersonal relationships either intensified the depression or conferred a protective influence. Their conclusion was that, "support for women must move beyond the medical management of depression and include a range of supports that take into account social, cultural, and other contextual factors" (Morrow et al., 2008, p. 600).

Nurse researchers Beck (1993) and Edhborg, Friberg, Lundh and Widstrom (2005) utilized a grounded theory approach to investigate women's experiences of PPD. Beck (1993) interviewed 12 women who had attended a PPD support group. Analysis of the data revealed that loss of control was an underlying theme of these women's experience.

Four stages that Beck identified as “teetering on the edge” emerged from the data; they are “(a) encountering terror, (b) dying of self, (c) struggling to survive, and (d) regaining control” (Beck, 1993, p. 44).

Edhborg et al. utilized the grounded theory approach to investigate the experience of the early postpartum period for Swedish women with signs of postpartum depression. They interviewed ten women at risk for depression as identified by the Edinburgh Postnatal Depression Scale (Cox et al., 1987) and concluded that women felt a sense of loss of their former selves and abandonment, were overwhelmed with childcare responsibilities, and had challenges with breastfeeding. Partner relationships were also noted as challenging. The women did not find it easy to voice their struggles, blaming their feelings on personal weakness rather than a mental health illness. The researchers concluded, “that depressed feelings postpartum may be explained in terms of losses and changes” (Edhborg et al., 2005, p. 266).

A methodology gaining in popularity for nursing research is a phenomenological approach. Since nurses need to ground their work in an understanding of people’s experiences of health and illness, this approach can contribute to disciplinary knowledge and to our understanding about the experience of PPD.

Beck’s (1992) phenomenological study was an early investigation into the lived experience of PPD. She interviewed seven women who had taken part in her PPD support group. Eleven theme clusters that formed the essence of understanding about this particular depression experience were identified in the data. The women described themselves as unbearably lonely as well as filled with thoughts of harming themselves and feelings of failure for not living up to the perfect mother image. They grieved for

their former lives, wondered if they would ever return to a sense of normalcy and felt a loss of control and concentration accompanied by overwhelming fear and guilt.

Beck (1992) compared the theme clusters with symptoms of depression as identified on the Beck Depression Inventory (Beck, Ward, & Mendelson, 1961) and the Edinburgh Postnatal Depression Scale (Cox et al., 1987). She determined that these screening tools do not include the PPD symptoms disclosed by the women in her research study. This phenomenological study highlighted the need for a more accurate quantitative instrument to identify postpartum depression.

Nicolson (1999) investigated PPD in a longitudinal qualitative study by interviewing 24 women during their pregnancy and postpartum period. They were not specifically identified to be at risk for depression but many had volunteered to be in the study, feeling that they might develop depression after giving birth. Nicolson's data analysis revealed the theme of loss as foundational to women's experiences. A sense of depletion after the birth of a healthy infant appears counterintuitive but women may lament the vanishing of their pre-motherhood lives. Nicolson suggested that PPD is not a medical illness and that, "some degree of postpartum depression should be the rule rather than the exception" (p. 176). She also stated that until society stops expecting the motherhood myth of the happy energetic new mother, PPD will continue to be medically diagnosed and treated.

Postpartum depression has also been studied in a nursing phenomenological hermeneutic study (Barr, 2008). Barr interviewed 11 women who were medically diagnosed with non-psychotic PPD. Her data analysis resulted in three key findings. First, adaption to the motherhood role was delayed. Postpartum women were no longer

identifying with nonchildbearing women, but they had not yet taken on the identity of a mother. Second, there was a delay in parenting skills. Third, a lack of maternal-infant attachment was noted. Barr's research supported, "clinical management of PPD to enhance the adaption to the mothering role, which includes developing new, realistic images of mothering, mentoring and timely education about parenting" (p. 363).

The qualitative approaches to PPD research reveal a psychosocial explanation of this transitional period in a woman's life. Rather than exploring biomedical causes and effects, they scrutinize PPD from the woman's perspective. Only when PPD is fully understood can supportive and effective services be put in place.

Summary of Literature Review

Research literature on PPD revealed a vast body of work that probed many aspects of this experience. Contributing factors such as hormone levels, anemia, thyroid dysfunction, proinflammatory response, previous depression and social factors have been discussed. In addition, the dramatic and adverse impact of this depression on women, their partners and children has been examined. Prevention and treatment modalities, largely dependant on the world view of the woman and her health professional, have been reviewed. Prevention modalities include depression screening, early education, debriefing, and alleviating risk factors. Treatment modalities include medication, Cognitive-Behavioural Therapy, Interpersonal Psychotherapy, non-directive counselling, and support group attendance. Finally, qualitative research approaches to study PPD have been sampled. These include ethnographic narrative, grounded theory and phenomenological studies.

My study adds to this impressive body of knowledge about PPD by offering women another opportunity to add their own voices to the research. Phenomenological research, while gaining in momentum, remains relatively uncommon in the examination of PPD. This study will offer a contextualized understanding of the experiences of PPD and identify identification (awareness/risk assessment), prevention, and treatment strategies amenable to nursing intervention. My research will therefore contribute to nursing research or disciplinary knowledge of the phenomenon. It also aims to raise public awareness of the effects of PPD by attending carefully to women's experiences and creating a visual representation of these experiences.

Chapter 3

Research Approach

The purpose of this phenomenological study was to investigate the lived experience of postpartum depression by way of conversational interviews and visual representations. A phenomenological study is one in which the researcher's goal is to fully understand and interpret a lived experience (Mackey, 2005; Mapp, 2008). Phenomenological research utilizes the knowledge that both the researcher and the participant have about the phenomenon in order to understand the essence of that experience (Wojner & Swanson, 2007). In this chapter I will discuss the research design including participant recruitment, ethical considerations, data collection, data analysis and rigour.

Study Design

The theoretical framework undergirding this research is Heidegger's interpretive approach (Wojner & Swanson, 2007). He assumed that understanding is the core of our essential selves, or our way of being-in-the-world. Our culture, personal history, activities, intersubjective and common meanings contribute to our understanding of the world. Heidegger proposed that we are dialogical beings and that our knowledge of the world is informed and shared through dialogue (Schwandt, 2000).

Dialogue is a foundational element of Heidegger's hermeneutic circle. Both the researcher and participant bring their essence of being, or being-in-the world, to the dialogue. The phenomenon under study is discussed in light of previous experiences, knowledge, assumptions and meanings. Interpretation develops and grows out of the dialogue and, as the hermeneutic circle would suggest, further interpretations appear as

the intersubjective meanings are shared (Schwandt, 2000). Therefore, interpretation and re-interpretation is expanded from a collective understanding between researcher and participant (Wojner & Swanson, 2007). Interpretations are offered tentatively, with the possibility that alternate understandings can be offered by those who are positioned differently in the world.

Those using an interpretive phenomenological approach to inquiry are encouraged to draw on their own knowledge and experiences as a resource for interpretation (Mapp, 2008). The expert knowledge of the researcher about the phenomenon is an asset and is a guide to meaningful inquiry (Lopez & Willis, 2004). The researcher's personal knowledge, biases and assumptions are welcome guests at the research table and acknowledged contributor to the acquisition of understanding. The researcher's Dasein, or way of being-in-the-world, is an essential element for exploration in the interpretive paradigm.

I have investigated postpartum depression using the interpretive approach for a number of reasons. First, I had personal knowledge of the phenomenon myself. Second, I have expert knowledge as a public health nurse with a lead role in a PPD support program. Third, I value a research approach that supports engagement in the process without having to set aside the researcher's biases and assumptions (Mapp, 2008): I brought my own Dasein to the research. Fourth, I was enthusiastic about entering into a hermeneutic circle of meaning making with women who had undergone this form of depression, anticipating that it would lead to the generation of rich, thickly contextualized data. Fifth, phenomenological research methods support the use of nontraditional sources of data (Mason, 2002; van Manen, 1997). My participants' visual representations of

postpartum depression were a very personal and productive way to elicit creative, meaningful information about the phenomenon. Finally, an interpretive phenomenological study is particularly relevant for the discipline of nursing. If nursing is a caring practice (Benner & Wrubel, 1989) it is essential that nurses understand the experience of their clients or patients.

Participants

Participant Recruitment

I received a Human Research Ethics Board Certificate of Approval from the University of Victoria prior to seeking participants. Those who eventually took part were recruited by advertising on posters, a magazine, local newspaper and word of mouth.

My plan was to prominently display posters in fabric stores throughout Victoria (see Appendix A, p. 129) to advertise my research study and contact information. This turned out to be a challenge. Two stores would not accept the poster, one other displayed it on a cluttered community notice board at the rear of the store and a fourth posted it at knee level below the cash register. Although I had thought fabric stores a natural place to recruit women for a research study involving fabric art, no women were recruited from these venues.

Both my husband and I also displayed posters in our places of employment; staff areas of Vancouver Island Health Authority (VIHA) South Island health units and a provincial government office building in downtown Victoria. I also sent a brief email to colleagues drawing attention to the posters and requested to have interested family, friends or colleagues contact me. In addition, I placed small advertisements in Island Parent Magazine and the Daily News newspaper.

Five participants volunteered for this study. This participant group enabled me to gain an in-depth understanding of the phenomenon (Mackey, 2005; Maggs-Rapport, 2001; Penner & McClement, 2008; Wojner & Swanson, 2007). I added to this understanding by sharing my own knowledge and experience of the depression (Mapp, 2008). I thus entered into the hermeneutic circle of understanding with each woman (Koch, 1995; Wojner & Swanson, 2007).

I used purposive sampling (Morrow, 2005) to recruit women who had recovered from depression or sadness after childbirth, were willing to illustrate their experience with fabric art and were willing to engage in a conversational interview and focus group. A medical diagnosis of postpartum depression was not necessary for inclusion in the study. Selection of participants with such personal knowledge of PPD contributed greatly to understanding the experience. (Mapp, 2008; Morrow, 2005).

One woman contacted me after seeing the poster in my husband's building, another was recruited by a relative who was a professional colleague of mine, three saw the ad in *Island Parent Magazine*, and two were recruited through word of mouth via Victoria midwives. Of the seven women who contacted me, four took part in the study. The fifth canceled our initial meeting and could not arrange a follow-up. A sixth disclosed, in our initial phone conversation, that she continues to experience psychotic depression. I did not ask her to participate, concerned her involvement may exacerbate her psychosis. I had an initial meeting with a seventh woman to explain my study and give her the fabric square; after three months she withdrew without starting on her square and I had not collected any data from her. Although I had planned to have five women in my study, I decided to continue with four.

Description of Sample

The four women recruited had self identified as experiencing PPD in the past. All were Caucasian, English speaking and had given birth in British Columbia. All had been in stable relationships with the father of the infant at the time of the birth. Two experienced PPD after their first birth, one after the birth of her second of four children, and one after her second of two children. At the time of their infants' births, two women were students and two were stay-at-home mothers. There was diversity in the length of time between the participant's depression and involvement in this research study; the shortest was just months, the longest was 27 years.

Research Ethics

The University of Victoria Human Research Ethics Board granted a Human Research Ethics Board Certificate of Approval for my study and a Participant Consent Form was created (see Appendix B, p. 130). The consent form was reviewed with each participant three times; a) at our first meeting, b) at the beginning of the face to face conversation, and c) at the beginning of the focus group. At each time I gave the participant an opportunity to ask any questions, inquired if she was comfortable to proceed and invited her to sign the consent form. Confidentiality was maintained throughout the study. Identifying details and names were altered in the transcripts. My introductory comments in the focus group again stressed confidentiality and an offer for participants to use a pseudonym if they wished to remain anonymous. All participants had moments of mild distress during the face to face discussions. I offered to turn the audio-recorder off and terminate the interview but they all declined. I was aware that conversations with vulnerable participants could become pseudo-therapy sessions (Owen,

2001). Some people derive therapeutic benefit from discussing a troublesome time in their lives, and it may have been the first time any of the women had discussed their PPD experiences with anyone (Reinharz & Chase, 2001). When a participant became upset, I gave her some time to express her feelings and then, with her consent, we resumed the conversation.

Data analysis began immediately after the first individual conversation. I transcribed three of the four individual conversation tapes verbatim and had one professionally transcribed. I also transcribed the focus group tape verbatim. The transcriptions were produced in electronic and hard copy formats with identifying information, such as names, replaced with initials. Both tapes and paper transcripts were stored securely in my home office. The fabric art that had been sewn together to make a wall hanging (Appendix C, p. 136) and my written observations and insights were also stored securely in my office.

Data Collection Procedures

Data was collected in three ways. The variety in data collection techniques ensured a richness and depth in quality of data collected (Morrow, 2005). Data was first gathered via a visual representation created by each participant (Cerbone, 2008; Mason, 2002; van Manen, 1990). This depiction using a visual representation was the foundation for the conversational interview (Corbin & Morse, 2003; Mapp, 2008; Penner & McClement, 2008). A focus group was the third method of data acquisition (Jamieson & Williams, 2003; Warr, 2005; Wilkinson, 1998). Each method of data collection will be discussed in turn.

Art as Data

I had an initial meeting with each participant to explain the research project and give her a 14 inch square piece of white fabric. She was invited to paint, draw, sew or glue a visual representation of her post-childbirth experience on the square. I stressed that her artwork could be as abstract or realistic as she chose to make it. A reimbursement of 50 dollars for art supplies was offered to each woman.

Heidegger stated that art was an important method of revealing the truth of the world and being-in-the-world (Cerbone, 2008). “The suggestion is that the work of art makes something manifest that would otherwise pass unnoticed” (Cerbone, 2008). As postpartum depression has gone unnoticed for years; artistic portrayal of the experience is a method of expression for the artist, a source of rich data for the researcher and a means of increasing awareness for society.

An increasing number of studies support the use of art as a mode of inquiry. Harrison (2002) and Guillemin (2004) discussed the usefulness of visual illustration in research. Wang and Burris (1994) described photo novella as a tool for empowerment in feminist theory research. Hagedorn (1994) utilized hermeneutic photography to understand families’ experiences of health and illness. Similarly, Guillemin explored the use of research participants’ drawings as a way of appreciating their illness. Price et al. (2007) studied the resonance of aesthetic inquiry, concluding that artist participants come to a deeper understanding of their disease, such as cancer or strokes. In addition, the artistic portrayal elevates public awareness of the illnesses. Baumann (1999) stated that art is a compelling method of investigation; it “is inquiry, a way of asking questions,

seeking information, provoking thought, communicating, and offering something about the world as perceived by humans” (p. 107).

Conversational Interviews

Prior to the conversational interview, I had brief contact with each woman when giving her the plain fabric square. At that time I also offered her an overview of the study, answered any questions and asked her to sign the consent form (Appendix B). This initial meeting was not audio-taped as its primary focus was passing on the fabric square.

After each woman completed her square she contacted me and we arranged to meet for an individual face-to-face, non-structured conversational interview. We met at a place of the participant’s choosing and at a time that was convenient for her. Two took place in the participant’s home, and two were in a VIHA facility meeting room that was convenient for the participant. We talked between an hour and two hours and I concluded the dialogue when it appeared that the conversation was becoming repetitive (Mapp, 2008). Each conversation was audio-recorded with participant knowledge and permission.

I began each dialogue by first reviewing the consent form and then asking the participant to show me and describe her fabric art; I specifically asked each woman to explain how the images reflected her experience with PPD. The artwork served as a prism that reflected the various aspects of her experience that we explored further in conversation. The discussion was not constricted by a rigid plan nor was it completely unstructured. It was open and fluid while grounded in the visual representation in front of us (Smyth, Ironside, Sims, Swenson, Spence, 2008). Fundamentally, the interview was an interaction of researcher and participant Dasein to explore her experience (Koch, 1995)

and generate rich data. When I found that the conversation was off topic, I focused it again on the PPD experience referring to the artwork.

During the conversations, I jotted very brief notes when I wanted to explore a participant's statement further; I made every effort to avoid interrupting her flow of ideas. Some researchers recommend that notes be taken throughout the interview (Crist & Tanner, 2003) but I found that this interfered with being present with the participant. Smyth et al (2008) encourages, "an openness that trusts the 'whole being' of the researcher will be caught up in the play of the conversation" (p.1392). As this openness was essential to the dialogue, I also wrote brief notes afterwards to reflect my initial impressions of the data, develop questions for possible further discussion in the focus group, and make comparisons between the participant's experience and current research findings. This material was an integral element of the hermeneutic circle: a fluid back-and-forth integration of new data and pre-existing knowledge and experience of the researcher and participants (Wojnar & Swanson, 2007).

Focus Group

A focus group was assembled after completion of the individual conversations. The focus group gave me the chance to validate my initial findings and discover if I had missed any relevant data (Jamieson & Williams, 2003). It also afforded the opportunity for the participants to generate further data through discussion with one another (Wilkinson, 1998b). Three of the four participants attended; one did not, having forgotten about the meeting. As I had already rescheduled the group once, I decided to continue though it has suggested that a focus group must have a minimum of four participants

(Clark, Maben, & Jones, 1996; Sim, 1998). I believed that a group of three could add sufficient rich data to make it worthwhile to proceed.

I conducted the group with the help of a professional colleague who is a peer researcher in a master's in leadership program. During the phone calls with participants to arrange the focus group I asked each for consent to have my colleague present; all gave their oral consent. I also offered each participant the option to use a pseudonym during the interview. My colleague was present for note taking and observations so that I could concentrate on facilitating (Beyea & Nicoll, 2000; Clark, Maben & Jones, 1996; Mansell, Bennett, Northway, Mead, & Mosely, 2004; Sim, 1998). In addition, the conversation was audiotaped, which I transcribed verbatim (Jamieson & Williams, 2003); the notes and transcript were included with the individual discussion transcripts for analysis later.

The focus group was held in a comfortable room in a centrally located community centre (Jamieson & Williams, 2003). Participants arranged themselves around a table on which nutritious snacks and beverages had been placed. I reviewed the purpose of my research and suggested ground rules for respectful interaction and confidentiality. There is no absolute guarantee that participants will maintain confidentiality, however all participants agreed to not repeat information in our discussion outside of the meeting room (Jamieson & Williams, 2003; Parahoo, 2007). I asked the participants to introduce themselves reminding them that they could use a pseudonym should they wish to remain anonymous. Participants reviewed and signed their consent forms. I then presented the completed wall hanging, which consisted of everyone's square, including mine. I had created and added one square representing my journey with PPD so as to be congruent with interpretive phenomenology wherein both researcher and participant bring their

experiences and assumptions to the research (Dowling, 2004; Mapp, 2008; Penner & McClement, 2008; Wojner & Swanson, 2007). The women were invited to comment on their square and I gave a brief explanation of my square. An open discussion ensued about their experiences with PPD.

It has been argued that a focus group is inappropriate in phenomenological research as it is difficult to understand the essence of a phenomenon in a group setting (Webb & Kevern, 2001). Others suggest that the presence of other participants decreases researcher influence, therefore contributing to unconstrained discussion (Owen, 2001; Wilkinson, 1998a). I found many advantages in conducting the focus group. The women generated rich data by participating in high level discussion, asking each other for clarification and identifying similarities and differences in their own experiences (Jamieson & Williams, 2003; Nyamathi & Shuler, 1990; Twinn, 2000; Warr, 2005; Wilkinson, 1998b). The group also gave me an opportunity to clarify ambiguous data from the previous individual discussions (Jamieson & Williams, 2003). No identifying information was included when I was discussing the previous data so as to maintain confidentiality. While it was helpful for me to be knowledgeable about PPD (Jamieson & Williams, 2003; Clark et al., 1996), I felt it necessary, and most valuable, for the participants to take the lead in the discussion. My role was to provide unobtrusive control (Clark et al., 1996; Nayamathi & Shuler, 1990; Sim, 1998). This group was very successful in that they developed a synergy that garnered valuable data that augmented my preliminary findings.

Data Analysis

Analysis of the data was a circular activity moving back and forth between the present knowledge of researcher and participant, and new understanding about the phenomenon (Crist & Tanner, 2003; Leonard, 1994; Wojner & Swanson, 2007). I entered into the hermeneutic circle of enquiry by immersing myself in the data and playing each tape several times to get a sense of the participant's experience. I listened to the words but was also sensitive to changes in tone, hesitations and general flow of the conversation. Afterwards, I listened to the conversations again while simultaneously reading the transcripts. This both enhanced immersion in the data and ensured transcript accuracy. I reread the transcripts numerous times noting metaphors, declarations, repetitions and contradictions (Aita, McIlvain, Susman, & Crabtree, 2003; LeCompte, 2000). I also hung the artwork in my office so that I could reflect on and make notes about the visual data while listening to the tapes. This interpretive work revealed general categories and emerging themes. (Maggs-Rapport, 2000; van Manen, 1997).

I wrote a summary for each data set, which consisted of each participant's interview and fabric square; the summaries highlighted my initial insights about the participants' experience. As I revisited each summary I reviewed and revised my interpretations. "To be able to do justice to the fullness and ambiguity of the experience of the lifeworld, writing may turn into a complex process of rewriting (re-thinking, re-reflecting, re-cognizing)" (van Manen, 1997, p. 131). The end product was identification of "exemplars" or meaningful vignettes that illustrated the themes I had uncovered (Crist & Tanner, 2003; Leonard, 1994; MacIntyre, 2001). Exemplars reflect the participant's individual experiences and are the fundamental building blocks in the identification of

themes. For example, feelings of isolation were conveyed in all conversations contributing to the theme of “cast adrift”.

In addition to exemplars, paradigm cases were also identified. According to Crist and Tanner (2003) these are “vibrant stories that are particularly compelling and to which the team tends to return, to examine from new perspectives” (p. 204). There were many gripping stories in the four interviews that acted as lightning rods for the generation and validation of themes. They were also particularly powerful in encouraging a deeper exploration of participants’ experiences. Examples of paradigm cases are the terrifying episodes of intrusive thoughts that the women experienced. One particular episode served to contribute to my understanding of being ‘torn asunder’.

Rigour

Rigour is the concept of demonstrating reliability and validity in research (McBrien, 2008) and reveals researcher integrity and competence (de Witt & Ploeg, 2006). There are a range of criteria to determine the rigour of scientific studies in the literature (Armour, Rivaux & Bell, 2009; Kvale, 1996; Lincoln & Guba, 1985; Morse, 1991; Morse, Barrett, Mayan, Olson and Spiers, 2002; Munhall, 1994). For example, discussions involve the timing of validity and reliability evaluation, whether the reliability and validity standards are foundational elements of the research design or whether rigour should be evaluated at the completion of the study (Cohen & Crabtree, 2008; Morse et al., 2002).

Morse et al’s (2002) work was used to evaluate the rigour in this phenomenological study. Verification strategies for ensuring rigour are investigator responsiveness, methodological coherence, theoretical sampling and sampling adequacy,

an active analytic stance, and saturation. In addition, rigour must be incorporated from the inception of the research study (Morse et al., 2002).

Investigator Responsiveness

Investigator responsiveness is fundamental to valid and reliable research. (Morse et al., 2002). Research is dependent on the skills and abilities of the researcher. “It is the researcher’s creativity, sensitivity, flexibility and skill in using verification strategies that determines the reliability and validity of the evolving study” (Morse et al., 2002, Investigator Responsiveness section, ¶ 1). I used an imaginative method of gathering data by asking participants to make a visual representation of their experience with PPD. The analysis of both visual and verbal data required a flexible, iterative process of constant re-writing and returning to previous understandings. Both my own ‘fore-understandings’ and the perceptions of the participants were involved. Sensitivity was demonstrated by going back to focus group participants to receive feedback on my initial perception of their experience. One must be sensitive and open to changes in insight to be able to accomplish reliable research (de Witt & Ploeg, 2005). I found that analysis was a fluid process that encouraged the constant re-evaluation of understandings.

Methodological Coherence

Methodological coherence was evident throughout this study. Coherence was demonstrated by the consistency of my own world view, the research methodology utilized and the analysis process undertaken. For example, in terms of my own world view, in asking women to provide an artistic expression of their PPD experience I demonstrated my belief that there are a myriad of methods to convey one’s narrative - that there is no one correct response. New concepts and ideas were inculcated through

researcher-participant dialogue, which led to greater understanding of phenomena. These fundamental tenets of Heidegger's interpretive approach closely reflected my own way of being in the world.

Methodological coherence was also shown in data analysis that was grounded in dialogue. Many forms of dialogue were analyzed to come to an appreciation of the lived experience of PPD: 1) dialogue between the participants, and myself 2) the visual data and myself, 3) my research notes and myself. Data analysis in the interpretive approach was undertaken by a process of writing and re-writing (Crist & Tanner, 2003), which can be regarded as a form of dialogue. I entered into a dialogical relationship with notes I had written previously; in the time since I had written them I had come to new insights into the participant's experience. Similarly, each time I listened to the audio-tapes they augmented my perceptions causing me to ask more questions of the audio data. This dialogical process demonstrated methodological coherence for analysis.

The validity and reliability of this research was demonstrated by coherence to phenomenological methodology in participant recruitment. Purposive sampling is imperative to interpretive phenomenology, and adequate data sampling is necessary to ensure saturation (Mapp, 2008). To ensure this adequacy, in the individual interviews, we discussed each participant's experience of PPD until the conversation elicited no new information. The focus group context provided an opportunity for participants to add further information about the phenomenon of inquiry. Each participant's contribution of artwork broadened the data base even further.

Active Analytic Stance

An active analytic stance was demonstrated by collecting and analyzing data concurrently (Morse et al., 2002). I immediately began the iterative process of analyzing data as soon as each interview was complete. I wrote notes regarding my questions and insights as I became increasingly familiar with the data, then re-examined the data with renewed vision and understanding. It was as though I was on a spiraling journey of understanding. Data from the focus group was incorporated into this process and exploration of the lived experience of PPD continued and, in fact, continues to this day.

Summary

Heidegger's interpretive approach was utilized to examine the lived experience of PPD. A purposive sample of four women who had experienced and recovered from postpartum depression was obtained. The University of Victoria Human Research Ethics Board gave approval for this research and I created a consent form that all participants signed. Confidentiality, informed consent and anonymity were maintained throughout; there is no guarantee that focus group participants will maintain confidentiality, but all agreed to keep the information discussed in the group to themselves (Jamieson & Williams, 2003; Parahoo, 2007). The participants and I each created a fabric visual representation of the PPD experience, which were then sewn together to create a wall hanging. One audio-taped individual conversation took place with each participant, lasting between one and two hours. Following the completion of the face-to-face interviews, all participants were invited to a focus group. Within the focus group setting, the completed wall hanging was shown to participants, which led to further discussion

and helped to enrich the data base. Both individual conversation and focus group audio-tapes were transcribed verbatim.

Data analysis was an iterative process that consisted of immersing myself in both audio and visual data, writing reflections and insights, and looking for exemplars and paradigm cases. Themes gradually emerged through this process. Rigour was adhered to through interpretive methods that were validated by my responsiveness, methodological coherence, sampling adequacy, an active analytic stance, and saturation.

CHAPTER 4

Research Findings

Introduction

The purpose of this interpretive research study was to explore the lived experience of postpartum depression (PPD) and by doing so, gain insights into this phenomenon that can inform nursing practice. As an interpretive researcher, I began the investigative process by examining my own fore-understanding of PPD. I then delved into the experiences of my participants via individual conversational discussions that began with their explanation of fabric art they were to undertake. Afterwards, I invited them to a focus group where my initial findings were reviewed. Finally, I reflected on the information I had collected to understand the essence of postpartum depression. “The interpreter tries to interpret the situation, presenting texts as fully as possible whilst pointing out where their understanding has been confirmed or negated by the participant’s comments” (Maggs-Rapport, 2000, p.221). The interpretation led to the generation of three themes that illustrate the essence of PPD.

Researcher Fore-Understanding

I came to this research self-consciously immersed in my own life history (Bergum, 1989; Maggs-Rapport, 2000). I have both personal and professional experience with PPD and have been intrigued by this mental health issue for many years. My own experience of PPD was a feeling of overwhelming numbness. My square on the left lower corner of the wall hanging portrayed a telephone with chains wrapped around it lying at the bottom of the sea, signifying my difficulty with communication, particularly on the telephone. It was a huge effort to answer it when it rang; it was next to impossible to initiate calls.

Communication with those around me was similarly difficult; I simply did not have the energy it required. The underwater image captured my daily existence with PPD; colours were muted and all movement seemed slow and laborious. Unlike many women who have extremes in emotions ranging from sadness through anger to mania, I had one: flatness. On top of it all was a layer of guilt; ‘why couldn’t I feel happy?’ To echo the women in this study, there was surely something wrong with me. What I now understand more fully is that my experience was mild and resolved as quickly as it arrived. My sister told me she felt much the same way after the birth of her infant and my family physician reassured me that I was not ‘nuts’. This, with the solid support of family, broke the chains and allowed me to surface. My experience was but a barely perceptible scratch on the surface in comparison to many women’s journey, yet it obviously left an indelible impression.

Themes

Each participant had a unique experience of PPD but there were common thoughts and feelings among all their stories that resulted in the development of three themes. I labeled the themes as 1) ‘*cast adrift*’; 2) ‘*torn asunder*’; and 3) ‘*safely home*’. *Cast adrift* referred to the isolation and vulnerability many women experienced in their struggle with PPD. They believed that friends, family, even health professionals just ‘don’t get it’. *Torn asunder* is a reflection of the violent impact of PPD on women’s self-concept and the feelings of insanity they endured. Finally, the theme of *safely home* illustrated the positive outcome of PPD. After a long and perilous journey, lessons had been learned and blessings counted. In the section below I used examples from the individual and focus group conversations and wall hanging to illustrate the three themes.

Each theme is discussed in turn. Participants' identities have been changed to protect confidentiality.

Cast Adrift

The theme of *cast adrift* conveyed a lack of control over one's life, in addition to feeling isolated from one's support system. These feelings were further complicated by unfulfilled expectations and profound fear. The themes were illustrated through paradigm cases or the "strong instances of particular patterns of meaning" (Leonard, 1994, p. 59). Paradigm cases are "vibrant stories that are particularly compelling and to which [one] team tends to return, to examine from new perspectives" (Crist & Tanner, 2003, p. 204). The paradigm case that supported this theme was an example from Mary, who felt health professionals failed to help or listen to her. After the birth of her baby, she was cast adrift to take care of herself despite her many calls for assistance. Her midwife minimized her symptoms, advising her to take vitamin B12. Mary felt that the public health nurse had also let her down; she made the following comments about the nurse:

[She was] useless to me, absolutely useless. ... I even phoned different public health units, can you help me? Nothing. Even my midwife, who are my friends, they're like, 'oh well, yeah, it's just the baby blues... but I was like, nope, that's not what it is. I knew something was wrong with me, I knew it.

It was not until Mary phoned the midwife again and said, "okay, you have to listen this time. There's something wrong with me" that she finally received medical attention.

The theme of being cast adrift had four elements. These elements were; a) feeling lack of control; b) feeling abandoned; c) feeling disappointed; d) and feeling fearful and worried. The theme 'cast adrift brings the following metaphor to mind.

A woman climbs aboard the good ship “Postpartum”, she is full of the promise of a new life. She is looking forward to the birth of her baby and feels ready to face the challenge. The baby is born and the boat casts off. However, this particular boat has no steering or propulsion mechanisms so it drifts aimlessly downstream. The woman is used to being in control so the meandering of the river is a new and unpleasant experience. Every once in a while, the boat goes through terrifying and unexpected rapids. What is around the next bend - who knows? She feels at the mercy of the currents and begins to worry about the underwater snags that could do irreparable harm to her boat.

Everyone she knows is on shore and they all assume she is having a glorious time. They can't really see her clearly enough to know that inside she is desperately sad, but all are sure she is well. After all, she's on a lovely boat ride with her baby. She is doing all she can to scream to those on shore that she needs help, but most cannot hear her. Those that do hear either lack the tools or knowledge to grab her off the boat, or believe that she is over-reacting. On the woman drifts, feeling more and more abandoned and alone.

At times the boat comes close to shore and she tries to put on a brave face. Everyone has told her she's fine so she doesn't want to disappoint them. She doesn't want to disappoint anyone, and is already disappointing herself. She feels pressure from everyone to live up to the image of a happy mother on the trip of a lifetime. She feels conflicted; she wants to tell people she is not well but does not want them to think she is not able to cope. So she fixes a smile on her face and drifts on down the stream.

As the journey continues, she becomes increasingly panicked because her experience is less and less what she had imagined. She tries to understand why this journey is so different than her expectations. She wonders why she isn't enjoying the ride and asks herself over and over, 'what is wrong with me'. She sees other women on boats in the stream and they all appear to be functioning well. She no longer feels like the same person who climbed aboard the boat upstream, and she worries that that person has disappeared forever.

This interpretation of *cast adrift* summarized part of the essence of the women's PPD as discussed in the individual conversations, the focus group and conveyed in the wall hanging. Examples were drawn from the data to illustrate specific elements of this theme.

Feeling Lack of Control

All the participants acknowledged feeling a lack of control over their lives. The women were besieged by an unknown emotional force completely beyond their ability to manage. They experienced loss of control regarding unwelcome thoughts and emotions. Lack of control gave rise to a sense of vulnerability - being on the boat without a rudder in the middle of the stream. One woman said, "I just, I didn't know what to do with any of this, like this new world that I was basically being handed. Because before I had my daughter, I knew exactly my path." The symptoms of PPD had undermined the participants' ability to plan their future and control their lives.

PPD affected the daily lives of the participants. They felt that they were without the capacity to accomplish basic activities of daily living. This aspect of the depression proved to be a considerable challenge. Mary spoke of this challenge:

Just trying to get out the door. I couldn't pull it together. I couldn't remember the diaper bag and then my purse would be upstairs and then I'd have one shoe on and he'd be crying in his seat. And as soon as I would hear him cry I'd just start to vibrate. And I've heard kids cry before, they're babies, they cry because they can't talk, big deal. But he would cry and I would just freak right out. I just couldn't even deal with it.

The decreased ability to function was reiterated in the focus group: "like I couldn't, to get out of the house was ridiculous". The women appeared to be at the mercy of the depression and felt powerless to overcome it.

Lisa stated she felt "definitely, lack of control" in her early postpartum period, which she illustrated as swirling waves in her square on the bottom right corner of the wall hanging: "it's like there were waves crashing over me and I'm drowning". The waves conveyed turbulence - giving one a sense of the overwhelming helplessness she felt. The women also mentioned being deeply fatigued by the constant buffeting of their PPD. "It was so exhausting. It was absolutely, like yeah, it was like nothing I've ever experienced. It was just absolutely exhausting." The participants were stressed and exhausted by the effort needed to counteract the symptoms of their depression in addition to daily childcare tasks.

During the face-to-face interview, Debbie discussed her surprise about the unexpected onset and nature of PPD. Once again, there was no sense of being in command of her life; PPD had taken it over:

It just sort of knocks all that happiness and lightness of being out of you. Knocks the life out of you, or the light out of you and plunges you into this dark place and

you don't even know what happened. You can't even identify. Like you're walking around kind of like going OK, so like happened? What, you know, what happened?

Debbie's experience was particularly shocking for her as this was her second child and she had had no glimmers of PPD with her first.

Lack of control was also demonstrated through a metaphor of feeling trapped. Debbie wrote, "trapped", on her piece of the wall hanging, signifying PPD's ruling influence in her life. She spoke about this feeling in our conversation stating, "And feeling trapped and I'm not even sure what I felt trapped about. But I did feel like a caged animal actually". She later stated that she felt unable to feel happy about her daughter; "I couldn't quite get the lights turned up all the way there". I found this to be a very poignant statement; it spoke to Debbie's desire to have a happy life and the inability to fulfill this desire.

All participants voiced their experience with PPD as that of being taken over by the illness. They no longer had power over their lives; simply accomplishing the basics of daily life was an enormous challenge. It appeared that they were on a journey down stream, not sure where or when they would land on the bank.

Feeling Abandoned

Feeling abandoned was pervasive throughout our discussions. All of the participants had tried to reach out to friends, family or health professionals with varying degrees of success. It was as if the lack of recognition was fueled by a sense that their situation was not acceptable to society. I related this feeling to the metaphor of the woman in the boat calling to her friends and family on shore but not being heard.

The wall hanging included the image of a blue, broken heart. The broken heart portrayed the disappointment Joan felt as a result of the lack of response from her friends. Her sister, “called some of our friends that were close and said that they would help and so I just said, ‘listen, I’m having a really hard time, I’m here on my own’ and basically all those people ran. I didn’t hear from them”. Later in our conversation Joan related that her husband “just didn’t get it. He actually even called on friends and just said, ‘I’m really worried about Joan’, and they just again didn’t help”. Joan also experienced this lack of response with a health professional. The following excerpt of our conversation illustrated her frustration with a counsellor who, according to Joan, treated her dismissively:

J: And in that year, I think it was about, I want to say it was about six months in, I went to see a counsellor, a postpartum depression counsellor, and saw her once and then saw her once with ‘H’ and then the third time she said, ‘oh, you’re fine.’ And did you feel fine?

J: No, no, and so it just kept going on.

This lack of response was further isolating for Joan and caused her to question her symptomatology. She suspected something was wrong but the PPD counsellor told her she was fine; Joan then began to wonder if her feelings were just normal motherhood or if there was something else wrong with her:

When I got discharged from the postpartum counselling, I was, like, maybe I just, I don’t have depression. And so I just kept trying to talk myself out of it that whole time, that I actually didn’t know. I think that’s the case too that, when I say I feel like the system failed me, I definitely thought I had depression, but when I

was told I was fine to go and it was just like it's something I'm not feeling.

Something's wrong with me.

Despite Joan's calls for help to family, friends and health professionals, it was not until she broke down in her physician's office three years after the birth of her baby that she actually received medical attention. She felt abandoned by everyone because no one offered the help she requested and she perceived that they did not understand her situation.

Lack of professional support was a common issue; for some women it started in the hospital soon after the birth of the baby. Lisa related this story during the focus group:

And then the nurse came in and I told her what I was feeling and just got the pamphlet – again. And I was like thanks, like you know, great. ... And I could see it in her face she was trying but it was like it wasn't clicking so, and then I went home and I thought, oh it's just the baby blues, it'll get better, yeah.

Lisa later went to a counsellor she had seen a few years previously and again felt isolated and abandoned due to the counsellor's lack of understanding:

And I remember her looking at me and being like, like I could see in her eyes like, 'this is beyond my scope'. 'Cause I was looking at her and I'm like, this isn't, I remember sitting there and I'm like OK, you're great, you're a great therapist – counsellor, but you're not getting this, and it was just the worst feeling, like I was like, I just want someone 'to get it'.

Despite programs offered by local public health services to identify and support women at risk for PPD, the participants reported that these services did not help them. Some time was spent in the focus group discussing how the Edinburgh Postnatal

Depression Scale (EPDS) (Cox et al., 1987) screening tool was not helpful in identifying their risk for PPD. This contributed to their sense of abandonment:

I remember doing that screening tool and I just wanted to, like, flip it over and, just like, write, like, ‘help!’ Just like, everything subjectively that I was feeling but I felt, like, I had to do this circle and I remember purposely lying on some of the questions, just so I could, like, just like, get someone to help me.

I found this discussion very difficult given I had been on the working group that developed the PPD program for public health in Greater Victoria. We had chosen the EPDS (Cox et al., 1987) as a screening tool, believing that it would identify women at risk for this depression. I was dismayed to find that it was not as effective as I had expected. An entry from my journal reflects my discomfort; “I have a sense of contributing to women’s struggle with PPD rather than helping to support them. I guess we need to re-evaluate”. The comment refers to a re-evaluation of our PPD program. Further education is required to remind public health nurses to discuss the EPDS score with clients and ask if it is reflective of the woman’s experience. Nursing judgment is a vital foundation for accurate evaluation of risk for depression and is not replaced by the EPDS (Holden, 1994).

The desertion the women felt was increased by lack of response from those with whom they were trying to communicate. Their sense of isolation and abandonment increased and desire to communicate decreased when they disclosed their feelings, and did not receive an appropriate response. Lisa spoke of her interaction with her sister:

And I just said to her, you know, like, yeah, sometimes I think of, you know, the knife slipping and, you know, getting hurt by it, or whatever, and my sister being

like, 'oh, uh huh'. Like just, like not getting it. And I remember being, like, God, I can't, I can't say anything. I just didn't, I just didn't tell anyone".

Lisa spoke further about her sense of isolation in relation to her husband.

Listening to their stories, it became apparent that the women were so exhausted by the daily grind of living with PPD and trying to get help that they had no extra energy for casual communication. Lisa spoke of this isolation:

I just became really closed off and I just, my husband would come home from work and I would just be, just totally exhausted and I would just either burst into tears or be like nothing's wrong – it's fine. Like be really closed off.

Debbie related her experience with this sense of isolation, both in conversation and on her wall hanging piece with the word 'alone'. She summarized the cycle many of the women endured when they believed they could not disclose their depression, as those around them just "didn't get it". Debbie said:

I felt horribly alone. I mean I couldn't really, you know, admit to anybody what I was really feeling. Um, I mean it's not like I didn't say anything to anybody but the people that I did talk to about it, family or a few friends or whatever, nobody really got what I was saying. Nobody understood the depths of the sort of despair or all the negative emotions that I was experiencing. Everybody just sort of seemed to think that it was the baby blues and that it would get better. And then, you know, it almost, like, the worse it got, the more afraid I was to tell anybody about how bad it was. So it was almost like a catch-22.

The participants spoke of their experience of stigma associated with PPD. Family, friends and even health professionals did not seem to ‘get it’ nor did they appear interested in talking to the women about their struggle with PPD.

I just remember feeling a lot like I couldn’t tell someone or certain people because of, you know, the feeling, like, oh they’ll think I’m crazy or whatever.

And I just remember that feeling of, like, I really think people should talk about it.

Because that’s the only way the stigma’s going to be broken.

Edwards and Timmons (2005) discovered that women felt a self-inflicted stigma in addition to “an underlying stigma within the health care organization that leads to groups of health professionals lacking understanding of this severe and debilitating illness” (p. 471). The lack of professional support experienced by the participants in my study would support Edwards and Timmons’ findings. The motivating factor for most of the women’s participation in this study was to heighten awareness and knowledge about PPD in order to decrease the stigma. As Mary stated, “There needs to be more awareness - there has to be more awareness of it”. It would appear that communication about one’s experience with PPD can be a vicious circle: 1) reaching out but not receiving appropriate response; 2) no longer reaching out due to the unspoken message that it is not acceptable; 3) PPD remaining an unknown issue due to stigma of discussing it; and 4) lack of appropriate response to women who do reach out.

In summary, the abandonment the women experienced was profound. It called into question the legitimacy of their feelings, the strength of their relationships, and the reliability of the medical system. They questioned their feelings because they felt mentally unwell but were told by the health professionals that they were fine. The

disconnect between their feelings and what they were told made them wonder if their symptoms were real. The strength of their relationships was questioned because they believed that their partner and family should have given them more support if they truly cared. Finally, they questioned the reliability of the medical system because appropriate treatment was so difficult to find. Their isolation increasingly hampered their ability to ask for help and support, and led to feelings of being stigmatized.

Feeling Disappointed

Study participants were dismayed that the expectations of their lives after giving birth were unmet. They were confident women and had expected to thoroughly enjoy the transition into motherhood. All related that they had had healthy pregnancies, with no anticipation of postpartum difficulties. Being besieged by mental health challenges came as an enormous surprise. They felt disappointment that their postpartum experience was not the overwhelmingly positive experience they had expected. In addition, they felt disappointment that they could not adequately function in their motherhood role.

Perhaps the most eloquent expression of this was illustrated by the clock in the top right corner of the wall hanging. Mary stated that the clock was set at the time her son was born. “It is a clock and it’s a clock because the time, it’s time that I feel that I’ll never have back. . . . that’s the time, the moment I waited for my entire life, was I’m a mom. That’s all I ever wanted”. Yet instead of a joyful event, that moment was the beginning of her journey with PPD. Mary planned her life around the birth of her children. She and her husband ensured they had a house and were financially stable enough to live on one income so that Mary could stay home. Everything was in place, yet she could not

enjoy her much-anticipated transition into motherhood. The sense of disappointment was unimaginable.

Joan also felt let down by friends and family and illustrated her disappointment by the broken heart in the bottom central section of the wall hanging. “There was just lots of disappointment; friends and experiences and expectations and so that’s all the many pieces of the heart”. It appeared that Joan also felt a sense of disappointment with herself. She had planned a home birth but gave birth in the hospital this was a great letdown for her. She related that this was the “first step, that whole ... I should have been able to do it, thousands of women do it, right?” Joan felt that this was the first step into the whole postpartum depression experience. This feeling continued into the postpartum period; “I thought I should be able to do everything, because everyone else appeared to be able to”. Joan had expectations of herself, friends and family, yet no one fulfilled these expectations. Her sense of disenchantment and self-criticism was an integral part of her postpartum experience.

Debbie’s square on the upper left corner of the wall hanging also spoke to her sense of disappointment. On the left, upper diagonal part of the square were illustrations of her expectations of motherhood and childbirth – expectations that were met with her first child. On the right, lower diagonal part of the square were words that Debbie associated with her experience of PPD. She stated:

I just thought that those were the feelings that wove through everything and sort of broke, broke up what, you know, what should have been otherwise, been in the upper quadrant here. And should have been all joyful and overwhelming love and beautiful and celebrating my baby girl and the thrill of motherhood. ... But I just

sort of feel if I hadn't had the postpartum depression, I could have made, like, maybe filled up all of these squares with all of this kind of stuff.

Debbie's words that it 'should have been all joyful' conveyed a deep sense of disappointment in missing out on the jubilation of her child's birth. The tone of her voice as she spoke to me was laden with disappointment. She spoke about her PPD experience in a quiet, reflective manner. Regret and melancholy added to the portrayal of her feeling so let down. Research literature has identified experiences of grief and bereavement associated with PPD and Debbie's disappointment appears to support this analysis (Edhborg et al., 2005; Nicolson, 1990). There was a sense of grieving for what could have been, illustrated by the word "grief" on her wall hanging piece.

Feeling Fearful and Worried

Fear and worry were woven throughout the conversations. In addition, Debbie's artwork in the left top corner of the wall hanging devoted a whole square to intersected words "fear" and "fearful". This square represented her overwhelming sense of fear – indeed, nowhere else on the fabric square does she intersect two similar words. When she explained her fabric art work to me in relation to PPD she stated:

[I had] a lot of fear, a lot of fear ... yeah, there was huge amounts of fear, because, I mean there was a lot to lose. I had to worry about losing two babies. I worried about losing my marriage ... and in losing my marriage, of course, then there was also the risk of losing all the, whatever security I had ... and somehow ending up on the crazy edge of society.

Lisa also stressed that she had felt consuming fear on a daily basis about her baby's future. In the focus group she shared that, "I just remember, like, looking out the

window of the hospital bed and thinking, ‘she’s going to grow up and get lost’. Mine was always losing her, she’s going to get lost, somebody’s going to take her”. Lisa shared this dread with me in our individual conversation. She ‘obsessed’ over missing children like Michael Dunahee¹, reasoning that if this young boy could be abducted, so too could her daughter. She also worried about losing her child in a variety of other specific ways. She would imagine her daughter as a teen in a fatal accident caused by drinking and driving, or as an infant lost in the mountains or at the bottom of the ocean, or dying as a result of illness. Lisa also imagined being psychologically estranged from her daughter; “What if she is horrible?” and “And I just remember thinking, like, she’s just not going to come home or she’s just going to hate me”. Even contemplating her daughter attending kindergarten caused Lisa to worry about the future; “Like I’m going to go pick her up from school in kindergarten and she’s not going to be there and I became obsessed with it”. She stated that the ever-present anxiety about the future “was so exhausting. It was absolutely, like yeah, it was like nothing I’ve ever experienced. It was absolutely exhausting.” Lisa’s life was infiltrated with the ‘what if’s’ of the unknown future, so much so that she was unable to enjoy her life in the present.

Lisa’s bottom right square of the wall hanging echoed her fears. The lower left quadrant was a very dark portrayal of a deep ocean, black mountains and skies. She explained how these images related to her fear of losing her infant daughter:

And like any time I just saw water, like anything vast, I was just like she could be

¹Five year old Michael Dunahee was abducted from Blanshard Park Elementary School in Victoria, British Columbia on March 24, 1991. He has not been found.

at the bottom of the ocean and I wouldn't know where she was. That was my biggest thing, or she could be across there in those mountains and I wouldn't know where she was. Like, it was all to do with, ah, I would say the vortex of it was to do with losing her.

Lisa realized that her fears were not rational, yet they nonetheless dominated her waking hours.

Joan's fear was related to her present concern that her experience with PPD had potentially caused her daughter harm. Joan's career was in reproductive health so she was aware that PPD can contribute to adverse outcomes in children of mothers with PPD. This was discussed both in the individual conversation and the focus group, as well as being represented in Joan's contribution to the wall hanging. Describing how her PPD experience continued to impact her life she said: "And then, you know, hearing about articles and linking postpartum depression and children's happiness and so as a mother, of course, you know. We're always the key to our children's happiness and sadness." Her depiction of the broken heart on the hanging portrayed her uneasiness about her daughter. The fracture was the scar that remained unhealed due to worries about the unknown impact of PPD on her daughter's development and happiness. This was particularly poignant; her nurturing role as a mother would normally be to protect her child from harm, yet by virtue of the PPD she was fearful that she had caused harm. Joan spoke movingly in the focus group about her concern:

Well, I think for me just the impact on the kids. I don't know if that's a shared experience but I always, now that my daughter is almost nine. I think because I

saw someone and some of the things they said to me about it and, just, I always carry that piece. Would she be a different kid, if I hadn't gone through it?

Joan's fear of her daughter's future led to an unexpected insight for me. All the participants in this study stated at the outset that they had recovered from PPD. And yet, through our conversations I realized that PPD would always have an impact on their lives. They may no longer have had symptoms, but lingering scars remained, as illustrated by Joan's heart. Joan told me, "It'll always be a part of me". She summed up the focus group conversation about this aspect of PPD:

So maybe the piece for all of us is that there's a continued piece that, you know, you might be through the experience, but it's something that carries with you and maybe it's that you continue. Is it a different worry about our children than non-PPD moms?

Mary experienced fear throughout her PPD. She did not state outright that she felt afraid but she shared her worry about the future of her children, much as Lisa had done. "What if I died? Who would look after my kids?" And they were really intense thoughts. They weren't normal thoughts. And you know, 'what if my kids died? What if, what if they just fell out the window?'" During the focus group she confirmed that she also continued to worry about her children. "Yup, I worry about them a lot, yup, a lot. And a lot more than I thought I ever would. So if it has anything to do with postpartum I don't know but...".

It seemed that fear was a momentous part of the experience of PPD. At the time of their depression the participants feared for their infant's safety, or the loss of their infant. They also feared future events such as an end to their marriage or estrangement

from their child. Some women, like Lisa and Debbie, were intensely affected by their fears in the midst of their depression. Others, like Mary and Joan, had lingering worries and fears that PPD had coloured their future in ways yet to be discovered.

The theme of *cast adrift* captured the essence of an unexpected postpartum journey of these women. The women's intense isolation, disappointment and fear they felt was the essence of this theme and persisted in haunting them even in recovery.

Torn Asunder

Torn asunder was a theme incorporating many of the terrifying elements of PPD. The language the women used to describe their PPD experience was often full of violent references such as being torn apart, fractured, broken and cracked. I spoke similarly in my research journal when recalling my own experience with PPD, stating that I felt fractured. *Torn asunder* encapsulated the disturbing essences of a) loss of identity, b) fear of losing one's mind and c) need to escape.

A paradigm case is a particularly compelling example of a participant's experience that undergirds a theme (Crist & Tanner, 2003). The paradigm case that illustrated the *torn asunder* theme was a story related by Debbie:

And I remember as I was running down the street there was, I passed a back alley and there was a dumpster. And I just remember flashing, just a flash, of throwing my baby into that dumpster and continuing to run. And then worse than that thought, was the self-incrimination of that thought. Because I didn't want to hurt my baby and I didn't know where that thought came from.

This example of the terror that Debbie experienced when she had such disturbing thoughts was at the core of the *torn asunder* theme. It was as if women dealing with PPD

were in another world that made no sense. They questioned their sanity, wondering if they could trust themselves to be competent parents. The frightening thoughts that plagued the women were not congruent to their usual sense of self and contributed to a sense of lost identity.

Loss of Identity

The participants keenly felt this loss of identity. There was an impression that whoever they were before the baby was born had disappeared - the person they have become seemed to be at the mercy of the depression.

Lisa affirmed this when describing her square on the bottom right of the wall hanging. She stated: “the waves represent change and just movement and how my emotions were just very fluid and always moving. It just felt like nothing was constant. Like I just didn’t know who I was”. She also remembered thinking “this isn’t me”. She was no longer sure who she was; adding to the nightmare was her perception that those closest to her no longer knew who she was either. “And I’d be just like my old self and then I would just crash and be like nobody would know, and I couldn’t stop crying, and nobody would know who I was”. Lisa stated that during her depression, “I instantly doubted myself, whereas before I’d be so strong-willed and everyone loved that about me and I loved it about me”. Lisa had a formidable identity prior to PPD: happily married, attending university and working towards buying a house. However, with the depression she was beset with doubts to the point of comparing her unhappiness to actors in commercials. “Sometimes when I see an ad on TV - this was really strong when I was in the depths of the depression – if I saw a family on TV that had like more than one kid I

would be just like why are they so happy?” Lisa’s experience of PPD temporarily robbed her of the compelling, decisive personality with which she identified.

Mary also related to a loss of identity. She stated that she “really felt like I was just literally slipping away”. Her clock on the top right corner of the wall hanging illustrated this. The depression took time away from her, which she described as “that time that I was feeling that I should have been reading him stories or something”. She did not feel like herself and was unable to interact with her son as she had imagined.

Joan illustrated her loss of identity through the heart on the lower middle of the wall hanging. She used violent metaphors and imagery inherent in the theme of *torn asunder*:

Basically [the image shows] that my heart was broken. And I was broken – literally. You know, there’s all the, all the hearts layered on the big heart. It’s just, I basically felt like that I was shattered into many different pieces in having my daughter.

She later stated that she felt torn apart by the depression and used imagery that conveyed her sense of her very being ripped from her:

It’s like a tornado comes along and just pulls you totally apart and, like, the analogy that comes to mind is I’m trying to grasp and put myself back together but it’s so fast and so big that, that it’s just bigger than me.

Joan eventually took antidepressants and found that they helped her regain her sense of self: “I mean I literally was a different person after I took the antidepressants”. Similar to Lisa’s experience, Joan felt that her family did not know who she was when in the depths of depression. She said that, after the medication had taken effect, she asked

her husband, “Why didn’t you ever leave? He said, ‘I knew you would come back’”. This eloquently illustrated that both she and her family felt the loss of the person she was prior to PPD.

Debbie’s experience of being a stranger to herself was profound as illustrated by her dumpster experience. She had a hard and painful time accepting that the person who would consider putting her child in a dumpster was actually herself.

So was this traumatic in that anywhere in my entire being that I would be capable of thinking, never mind doing, but even thinking, having that concept come into my mind. ... So, yeah, this vision of me throwing my child into the dumpster was, like literally, like invasion of the body snatchers kind of thing.

Debbie’s self identity prior to her depression was an “earth mother” with one baby on one hip and one at the breast. The thought that she could have hurt her baby rocked her to her soul and was something for which she continued to feel guilty 27 years later.

The ‘invasion of the body snatchers’ metaphor represented for the women the core experience of their loss of identity. They felt this was something that had happened to them and was beyond their control. During their PPD journey, they perceived themselves as changing from self assured women to women that even they did not recognize.

Loss of Sanity

Loss of Sanity was an element of the *torn asunder* theme evident throughout the women’s PPD experiences. They stated that they were terrified they were losing their sanity. Questioning their own mental health was caused in part by thoughts of harming their infant. This was not an uncommon symptom; women were often deeply frightened

or ashamed by these thoughts but very rarely were they acted on (Ross, Dennis, Blackmore, & Stewart, 2005). Nonetheless, they were distressing, as evidenced by the women in this study, who continued to be haunted by them for many years after their recovery.

In our conversation, Debbie stated that, had she been a better artist her fabric art would have been a depiction of the dumpster. The millisecond thought she had about throwing her baby into it coloured her whole experience of PPD and made her doubt her sanity even now: “It’s just haunted me all these years”. Debbie devoted a square of her wall hanging piece to the intersected words, ‘crazy’ and ‘insanity’, which reflected the impact of these sensations: “I felt insane, I felt crazy. And I couldn’t make the feelings stop”.

Debbie stated that she experienced a Jekyll and Hyde duality to her depression. She felt that she had “crazy thoughts” and had to work hard to keep the crazy part of her hidden from public view.

You know where at least Dr. Jekyll/Mr. Hyde, he didn’t really have an awareness that he was, when he was one, he didn’t really associate with the other. But me, I’m walking around this crazy person but there was like this sane person inside my head that’s recognizing that there’s this crazy person up there too. And just thinking, like, I have to work really, really hard so that other people don’t see the insanity that’s existing inside of me.

The outward portrayal of normalcy was exhausting for Debbie and added to the overwhelming nature and terror of her experience.

In addition to the madness that she felt, Debbie experienced a type of emptiness; she conveyed this in her square on the wall hanging by leaving one small square empty. This represented for her, that void of emotion or, as she stated, “where you exist but you don’t exist”. She spoke about this as another aspect of the craziness that was no less unsettling:

There were, you know, periods where, that was preferable to, you know, the insanity and craziness and the feeling trapped and sad and being dead in there as well because there was that, I mean, that’s just another way of sort of talking about the nothingness because there was just this deadness, this ‘absence of’ sense, that, whatever.

‘Existing but not existing’ was a powerful metaphor to describe PPD. The participants conveyed that they felt like only a shadow of their prenatal selves. They existed in their new world, yet they were not themselves. It also reflected the feeling of being numb to the world. This resonated with me personally because, more than any other comment throughout all the conversations, this was an accurate reflection of my own experience with PPD.

The language Debbie used to portray her sense of insanity was full of violent references I interpreted as a reflection of the assault that these emotions had on her. “What happened with my second daughter ... was way more scattered and fragmented and broken”. She also conveyed her experience with the intrusive thoughts in brutal language; “It’s like you’re walking along and life is good and then all of a sudden being slapped up side of the head or punched in the gut or whatever”. PPD was a dramatic and very unwelcome assault on Debbie’s mental well-being.

Lisa also had the experience of feeling crazy. She had experienced depression previous to her PPD but the sense of disturbed sanity was new. “I actually felt like I was losing my mind”. With her PPD, she also had frightening thoughts about drowning her daughter or leaving her in the woods.

I could just put her down in the water and I could drown her and she would die.

And then, like, going, ‘oh my God’, like, absolutely horrible. I was, like, ‘what if

I left her in the forest? And I just left her?’ ... like crazy thoughts.

Lisa referred to these episodes as having dark thoughts, which are reflected in the somberness of the lower half of her piece on the lower right panel of the wall hanging. Lisa commented that, “nothing was sane” and was so ashamed that she never discussed these thoughts with her husband. The fact that she had these dark thoughts haunts her to this day.

For the most part Mary stated that she felt well during her postnatal period, but had flashes of distressing thoughts that made her feel she was going out of her mind:

They weren’t normal thoughts. And, you know, what if my kids died? What if, what if they just fell out the window? Like I would actually look out the window of the playroom and I could see them, like, splattered on the ground.

Her clock in the right top corner of the wall hanging shows the significance of these momentary flashes. Mary stated that the pink and blue colours represented her son and daughter; the hues are not dark “because postpartum isn’t all of me”. She said:

I wasn’t always feeling badly or always feeling that there was something wrong. I had really good days, a lot of really good days. ... Like if I ever had a bad moment in the day, it was a moment and it would pass as quickly as it came.

Despite having a number of “good days”, the momentary flashes of terror dominated Mary’s postpartum period, robbing her of time to spend with her baby. Many women’s PPD experience can be likened to a physical ache over a period of time, while Mary’s was one of feeling fine for the most part, punctuated with quick and excruciating flashes of pain.

During the focus group, Mary stated, “I was never sad or I wasn’t laying in bed. I was just out my freaking mind.” Despite usually feeling well enough, the momentary sensations were distressing enough to “freak” her out and convince her that she “was going insane”. Mary suggested during our individual conversation that postpartum depression should be renamed to “postpartum out of your fucking mind”. Many would agree.

Joan also experienced the crazy aspect of PPD and stated that she “felt like this crazy lady walking around”. She did not have the flashes of upsetting thoughts that the other women described, but she had longer episodes of disordered thinking:

I think I was borderline psychoses because I remember at one point, well for quite a while, I thought that my daughter believed that my sister was her mom and that my sister was breastfeeding her and you know that she didn’t really need me as her mom.

While the other women’s experiences of PPD appeared to be driven by the terrifying thoughts, Joan’s depression appeared to be more about the identity loss. No woman experiences PPD in exactly the same way, but all are forever changed by it.

Need to Escape

As I immersed myself in the data, the image of running came up in many discussions with the participants. It was such an omnipresent and evocative image that it needed my attention. I have interpreted the motion of running as a desire to escape the mad chaos found in *torn asunder*.

Debbie wrote, “run!!!”, on her section on the top left corner of the wall hanging. She shared that, although not a recreational runner, she had a compelling urge to run throughout most of her depression.

I felt like I wanted to run. It was this underlying feeling that was with me whenever I was in, you know, in the bad place. That, you know, I just wanted to run. And what I was running from I don't really know. But I just wanted to run. ... And I've never been a runner, so that was kind of weird.

It is particularly telling that Debbie wanted to run when she was in ‘the bad place’, when her depression was at its deepest. Perhaps her desire to run stemmed from wanted to run away from the depression.

Running was also a part of Joan's conversation; she was training for and running marathons and half marathons during the three years that she was depressed. Reflecting on her desire to run she suggested that “extensive running was keeping me a bit level, probably because [of] all the endorphins, you know”. The language of running was evident throughout our discussion; Joan mentioned a few times that she, “just wanted to run away”. Joan stated that after years of seeking help it was when she told her physician that she wanted to run away that she finally received medical care. Joan's running was

evident through actual physical exercise, through the metaphor of wanting to run away to escape and as the instigator for treatment.

Mary walked for many miles every day to escape her feelings of depression and insanity. She stated that she “walked from my house to [name of road] every day with him in the stroller and it’s about nine miles round trip”. Similar to Joan’s running as a method to control her depression, Mary suggested that her walking elevated her serotonin levels, making her feel better.

During the focus group I mentioned the strong thread about running and escaping throughout the discussions. The women agreed that during their depression, they felt the need to get out and walk or run in an effort to feel better.

J: I actually did marathon training just to get the endorphins to stay sane. I didn’t realize it at the time but...

M: I used to put the kids in the double stroller and walk; it was close to nine miles a day.

L: I remember I just wanted to get out and I didn’t want to talk to anyone. ... I wanted her to go to sleep in her stroller so I could just yeah, just walk.

J: It’s amazing how the body tries to heal itself because the serotonin that you’re producing when you’re exercising.

M: I know! It’s just dynamite amazing how it kind of knows – hey, get out there!

J: It would be an interesting question maybe on the tool. How much are you exercising?

I thought it interesting that all the women exercised or had a constant urge to exercise during their depression. Joan’s comment regarding the addition of a question on exercise

for the EPDS (Cox et al., 1987) was telling, as they all felt it could be an indicator for identifying a woman at risk for PPD.

Safely Home

The theme of *safely home* conveyed an image of returning home to safety after being on a long and perhaps perilous journey. Although the expedition was not pleasant, the travellers learned about themselves and their families. They also stated that they felt stronger both for the experience of having depression and recovering from it. A compelling paradigm statement (Crist & Tanner, 2003) that represents the essence of this theme was a quick comment that Mary made in the individual conversation: “Here I am, I made it through”. This created the imagery of surviving a difficult journey and perhaps being stronger for the challenge. Mary was not the only woman in my study who reflected this idea.

The wall hanging eloquently represented the positive aspects of having experienced PPD. Three of the five squares contained hearts representing the love the women have for their children and families. Half of Debbie’s square on the top left of the wall hanging was devoted to the positive aspects of motherhood reflecting her view that, although her experience with PPD was nightmarish, the good that came out of it was the birth of her daughter and the love she had for her children.

Mary’s square on the top right of the wall hanging was a light pink and blue clock supported by a pink or blue heart at each corner. “And the hearts are to symbolize the love that I have for my kids, [and for the love] that my husband had for me enough to pull me through it. ... It’s not ugly – I have two beautiful kids”. Mary stressed throughout our conversation that postpartum depression “wasn’t all horrible”. As previously discussed,

she related that she had good days and bad days but in the end was able to look back on the experience and appreciate the positive aspects. She made it through.

Joan's square on the bottom middle of the wall hanging portrayed a blue fractured heart layered with smaller hearts. The heart represented the joy and love of her baby's birth and the fracture illustrated the negative impact of PPD on those expectations. Throughout the interview she used words like broken, fractured, cracked, shattered, and splitting, all of which were evident in her wall hanging piece. However, Joan stated she is a stronger, more relaxed person than she was and she credited her experience with PPD for this positive outcome.

I became very clear, eventually, about exactly what I wanted to do and what I didn't want to do anymore. And I also let go of control. ... All I can do is just in this moment and I know, you know, that that's what that whole experience brought me. ... I'm very thankful, I wouldn't change it.

Lisa's fabric square on the bottom right of the wall hanging represented love and hope in the arrangement of the images she used. The bottom half of her square was dark representing the overwhelming negative emotions of PPD, the upper half was much lighter representing her hope for the future after surviving her passage through the depression. Her feelings of hope were illustrated by her painting of a Japanese cherry tree:

I just remember just feeling a little bit of hope whenever I saw them. And, yeah, that's why I drew those in there 'cause I just remember feeling like there's got to be, there's got to be something that's hopeful in here.

Much like the other squares that represented love of family, Lisa's cherry tree also represented this love:

I think the tree, too, also symbolizes a lot of family. My brother and sister, again, have been really great through it. Also, also, just even the people that weren't that great, I think, still gave me hope because they made me stronger.

The flower also conveyed a positive outlook. "The flower I drew kind of as a banner of hope and kind of growth at the same time and changing and just looking to brighter days". Lisa's journey was an overwhelming, desolate and frightening time, but as her fabric art suggests, those days fostered her growth and gave rise to a more hopeful future. She too made it through.

In contrast to the participants' positive images on the wall hanging, my piece did not have any positive or hopeful elements in it. This was an intriguing outlier as my love of my son and family were certainly never in doubt. I, too, was grateful for the experience as I believed I also grew from it. I would not have developed a professional interest in postpartum depression had I not experienced the phenomenon myself. However, during that time, and in reflecting back on it, I cannot say that I see anything other than a period of "existing but not existing".

The women in this study suffered greatly as a result of their experience with PPD. The love for their children and family contributed to their resiliency, strength and desire to continue searching for support and appropriate treatment. All stated that they learned about themselves as a result of the experience and, although they would not wish it on anyone else, they were grateful both for the journey and for arriving safely home at journey's end.

Conclusion

The women in this study articulated their journey through PPD in open conversations, a focus group and fabric art. I interpreted their experiences as wild, often frightening journeys that robbed them of their sense of self and had them believe their sanity was at stake. They had little control over this journey; they felt abandoned by everyone around them, disappointed their expectations were unmet and fearful of the future. Finally, through their diligence in seeking medical treatment, they arrived home to the safe harbour of their children, their families and a self they recognized. All reported feeling stronger, wiser and more hopeful because of the journey. They also voiced their commitment to sharing what they had learned in order to raise public awareness so that women in the future will recognize symptoms of PPD and seek support and treatment.

CHAPTER 5

Discussion and Implications

Discussion

My interpretive phenomenological study investigated women's lived experience of postpartum depression (PPD). Interpretive phenomenology is a research methodology utilized to understand the essence of a phenomenon. Researcher and participant presuppositions are included in the interpretive dialogical process. I engaged in an individual, open conversational interview with each of four women who self identified as having had PPD. Following the individual interviews, the women were invited to participate in a focus group. Each woman also created a visual representation of her experience on a square of fabric. The artwork was another form of data that generated rich images to augment the interview data. I contributed a square evocative of my own experience with PPD. The squares were sewn together to form a wall hanging that was presented at the focus group and stimulated further dialogue. Data analysis was guided by Crist and Tanner's (2003) analytic method for hermeneutic interpretive phenomenology. Three themes were identified that represented the essence of the PPD experience: 1) *cast adrift*, 2) *torn asunder*, 3) *safely home*.

The use of participant artwork as data augmented the rich descriptions obtained from both individual and focus group discussions. An artistic representation of an object or phenomenon can increase awareness of the object or phenomenon's existence. Heidegger used an example of Van Gogh's painting of peasant shoes; they were taken for granted when in use, but once portrayed in the painting, their colour and form became noteworthy (Cerbone, 2008). Similarly, Murray (as cited in Price et al., 2007) stated that

the artist Robert Pope, “shows the medical community how to see with new eyes what we see every day” (p. 156). The use of art in my study helped to convey the richness and depth of an experience that was lost in the everyday world.

Because art allows for transcendence, it may bring us paradoxically closer to the experience and provide a rich source of material for the phenomenologist, who is always asking, “what does it mean to be human? ... The work speaks to us and we hear it emotively and humanly. We become closer to finding meaning (Munhall, 1994, p. 116).

The fabric squares the women and I created conveyed a multi-layered, complex experience that was full of conflicting emotions, such as hope and despair. A viewer interprets the artwork through a personal lens, enters into an interpretive dialogue with the artist and experiences a fuller understanding of PPD.

Findings from this study suggested that women felt completely overwhelmed by their experience with postpartum depression. The onset was unexpected and they did not initially label their experience as PPD but all stated they knew something was wrong. They attempted to get help from counsellors, public health nurses, midwives and physicians with little immediate success. This resulted in a delay in treatment and unnecessarily prolonged their suffering. All finally received treatment with prescribed medication or by attending a PPD support group or a mother and baby play group.

Within and in addition to their experience of PPD, the participants in my study experienced the transition from non-childbearing to motherhood. Research on becoming a mother showed that the transition is often far different from the heartwarming experience many women anticipated. The women in my study struggled with their new

role and felt enormous guilt and fear with the challenges inherent in their transition. Eventually, they were able to incorporate and embrace the mother role into their self-concept and in doing so, felt stronger and more confident for the journey. My research demonstrated that the experience of becoming a mother and the experience of having PPD had overlapping elements; becoming a mother was not exclusively a positive experience and PPD was not exclusively a negative one. My research findings would suggest that all mothers must be supported in their transition, no matter what their experience.

In this chapter the contributions of this research, study limitations, implications for nursing practice and suggestions for future research will be discussed

Contributions of the Study

Each woman spoke of both negative and positive aspects of PPD while in conversation with me. They continued to be haunted by their experience, despite stating they had recovered from the depression. They also spoke of their love for their family and stated that the love of their family and for their children sustained them through the dark times they endured.

A significant finding of this study was that women carried residual worries and guilt originating in their depression, despite identifying themselves as having recovered from PPD. I had attempted to recruit women who had experienced PPD and had fully recovered, but my findings suggested that women do not completely recuperate from this depression. They continued to worry about the effects their depression had on their children and wondered whether possible attachment disorders were a result of their PPD. Women carried enormous guilt about their intrusive, frightening thoughts of harming or

losing their infants. The passage of time did not lessen these feelings as these concerns were voiced as frequently by the mother of a 27 year old as they were by the mother of an infant.

Despite ongoing worries and feelings of guilt, women stated that there were positive aspects to having experienced their depression. I had expected the women's visual images on the wall hanging to represent the dark thoughts and frightening experiences of PPD. In contrast, all of the participant squares contained hearts or positive representations of the love they felt for their families. Each woman spoke of both negative and positive aspects of PPD while in conversation with me: however the negative aspects drew attention as it was by far the more powerful narrative. It was not until I analyzed the wall hanging squares that I realized the underlying common image represented love for family.

The positive images suggested that love for family and the infant was an integral piece of the PPD experience. While the birth of the baby instigated the depression, women did not blame the baby or regret becoming a mother. In addition, three of the four participants believed their marriages to be stronger after their recovery from PPD; the women believed that if they could survive PPD, they could survive anything the future could bring. Women relied on their family of origin for support and found that these relationships also became stronger. Strength and love of family in the face of PPD was a significant finding of this study.

Summary of Themes

Analysis of interview and visual data resulted in the identification of three themes, which I labelled “*cast adrift*”, “*torn asunder*”, and “*safely home*”. I will discuss my findings in light of previous research studies on PPD.

Cast Adrift

Cast adrift had four elements that contributed to this theme; a) feeling a lack of control, b) feeling abandoned, c) feeling disappointed, d) feeling fearful and worried. The theme reflected the finding that the women no longer felt in charge of their lives. They had difficulty managing emotions and believed they had no power over their very existence. All had healthy pregnancies so postpartum complications were unexpected for them.

A loss of control is a common finding in PPD research (Beck, 1992; Beck, 1993; Chan, Levy, Chung, & Lee, 2002; Williamson & McCutcheon, 2007). Beck (1992) found that “loss of control of mothers’ emotions was alarming and difficult to accept” in her phenomenological study (p. 169). In her grounded theory study Beck (1993) found that a “loss of control was the basic social psychological problem in postpartum depression” (p. 44). Chan et al. (2002) utilized phenomenological research to discover that Hong Kong Chinese women experienced emotional and behavioural loss of control with PPD. Findings in Williamson and McCutcheon’s (2007) hermeneutic phenomenological study also suggested that loss of control was common in PPD. These studies reported diminished emotional control whereas my interpretation of loss of control represented the participants’ difficulty to avert the onset and course of PPD. Not only did it overpower their emotions, PPD overpowered their very lives. They had difficulty with simple tasks

of daily living and felt trapped within the depression. My findings of loss of control confirmed previous research and contributed a new understanding.

The second element of *cast adrift* was a feeling of abandonment that arose from participants' experience of not being heard by friends, relatives and health professionals, despite numerous cries for help. The women frequently stated that no one was "getting it". This finding confirms Edhborg et al.'s (2005) grounded theory study that explored women's experiences of the first postpartum months. In that study, Edhborg et al. suggested that women suffering from PPD felt abandoned and alone. Much like the participants in my study, the women in Edhborg et al.'s study longed for help and support, which was not forthcoming. Similar findings of women's experiences were reported by Beck (1993) in her grounded theory research about the lived experience of PPD and by Edwards and Timmons' (2005) qualitative study about stigma in women with PPD. The participants in these research studies complained that no one, including health professionals, understood what they were going through. Beck (1993) and Edwards and Timmons' (2005) attributed their participants' experiences to a sense of isolation while Edhborg et al. (2005) and I attributed them to feelings of abandonment. In either case this experience of abandonment and isolation engendered a sense that their feelings were not acceptable, further intensifying their stigmatization.

Feeling disappointed was another aspect of the theme *cast adrift*. Participants stated that friends, family and health professionals let them down by not offering appropriate physical and emotional support. In addition, they had expected to make a seamless transition into motherhood and felt great disappointment that they did not immediately enjoy their new role. Three of four participants in my study had looked

forward with great anticipation to having children; the disappointment they felt was particularly acute.

This result in my study confirmed the findings of previous research studies. Berggren-Clive (1998) utilized a feminist perspective in her qualitative study on PPD. She stated that, “many women anticipated that life with a new baby would be marvelous time” (p. 110). and they felt great disappointment when their experience was primarily one of negative emotions.

In addition to feeling disappointed by others, previous research suggested that women were disappointed in their own inability to function. They had high expectations of themselves, wanting to be the perfect mother but failing to reach that unattainable standard. In Edhborg et al.’s (2005) grounded theory study the researchers found that mothers had strong feelings of disappointment about their inability to breastfeed and to attain the perfect mother image. They were also disappointed that the challenges of an infant put stress on their marriage and that their partner was not more involved in the care of the infant. My findings confirmed these particular findings in previous research literature - a sense of disappointment was pervasive in the women’s experience of postpartum depression.

The fourth element of being *cast adrift* is the feeling of fear and worry. The wall hanging clearly reflected this by the intersected words “fear” and “fearful”. Participants spoke of an overwhelming fear of losing everything, of threats to their baby’s safety, of the unknown and of being estranged from their child in the future. One participant was afraid of not being able to find her baby, saying that she worried about this obsessively. Others voiced fear, particularly in the focus group, of the negative impact that PPD might

continue to have on their children. The women shared that this fear remained with them today, despite believing they had recovered from the depression.

My findings echoed previous research studies that suggested fear was a key component of PPD. Chan et al. (2002) found that this feeling was common for the participants in their phenomenological study on the experiences of Hong Kong Chinese women with PPD. The women lived in fear that something horrendous would happen to their infant. Another phenomenological researcher who investigated seven women's experience with PPD (Beck, 1992) discovered that women carried a burden of fear and guilt over thoughts of harming their infant. Previous research participants and the women in my study found this fear to be overwhelming and terrifying particularly because these thoughts were so incongruous to their self-concept (Edwards & Timmons, 2005). Women also worried that their lives would never return to normal and they would never again be happy (Beck, 1992; Beck, 1993). Fear appeared to be a predominant force in the experience of PPD.

Torn Asunder

The theme, *torn asunder*, contains three contributing elements; a) loss of identity, b) loss of sanity, and c) need to escape. Research literature strongly supported these themes as most women identified them as being part of their PPD experience. *Torn asunder* represents the most excruciatingly frightening aspects of this depression.

Loss of identity has been well documented throughout PPD research literature (Beck, 1993; Berggren-Clive, 1998; Edhborg et al., 2005; Mauthner, 1999; Nicolson, 1990). Women experienced a loss of identity in terms of the shift from independent professional to mother (Edhborg et al., 2005). In addition to the role identification,

women reported that they no longer knew who they were in a fundamental sense. In Beck's (1993) phenomenological study of PPD, "Mothers' normal selves were no longer present. Neither the women nor their husbands knew who these women were. Husbands asked where their wives had gone" (p. 45). The participants in my study corroborated this; they frequently questioned themselves, wondering what had happened to the person they once were. One husband told his wife that he knew she would come back to him, eloquently illustrating the loss of identity – evident to him as well as her.

Loss of sanity is an essential component of being *torn asunder* and has also been noted in many studies. In these studies, women questioned their stability due to the endless frightening thoughts of harm being inflicted on their infants (Beck, 1992, 1993, 1996; Edwards & Timmons, 2005). Beck (1992, 1996) found that an absence of emotion was also experienced, in direct contrast to these distressing thoughts, but both contributed to the feeling of losing one's mind. A participant in my study referred to her sense of emotional void as "existing but not existing"; one woman in Beck's (1996) study stated, "you're there and you're not there" (p. 100).

The concept of existing but not existing was reflected in Barr's (2008) phenomenological hermeneutic research on delayed maternal adaptation. Her findings suggested that women became stuck in a liminal state, "when change has begun but the person has not yet reached the new social position or status" (p. 363). This phase was one of ambiguity wherein a woman was no longer childless but had not yet transitioned to her new role as a mother. In addition, research had shown that the transition into motherhood took much longer than the time to give birth. Women with mental health issues may not fully embrace the motherhood role until well into the first year of the baby's life

(Logsdon et al., 2006). The women in my study were not only in emotional limbo they were also in limbo with regard to their new motherhood role.

My participants' experiences confirmed nursing research that suggested the transition into motherhood was challenging for many women. The women in my study related that they did not know who they were in the early postpartum period, which confirmed the findings of nurse researchers Barclay et al. (1997). In their grounded theory study on the transition to motherhood Barclay et al. found that women underwent a lengthy metamorphous of their self-concept; they lost one identity and eventually, over many months, gained the identity of a mother. The participants in my study also experienced many of the same feelings and emotions as the participants in Barclay et al.'s study; they all they felt lost, vulnerable, isolated, tired, grief-stricken, and frightened. The postpartum period was shown to be daunting for women, no matter what the state of their mental well being.

In their research report on the misery of motherhood Barclay and Lloyd (1996) identified loss as a conceptual framework for the transition into motherhood. Not only was there a loss of identity, there was also a loss of the ideal expectations about the experience of motherhood. The participants in my study felt acute disappointment about unfulfilled expectations, confirming that women experience loss and disappointments whether or not they are struggling with PPD.

An interesting finding in nursing research on becoming a mother was that some concepts were identified as positive elements of the transition; such elements, however, were interpreted as negative by my participants in their discussion of the PPD experience. For example, the concept of fragmented thinking was identified by nurse researcher

Bergum (1997) in her phenomenological research on becoming a mother; this form of thinking was confirmed by participants in my study. Unlike the participants in my study, Bergum viewed fragmented thinking in a positive light as a “way of thinking that moves from self to child and back to a self that is more reflective, more conscious of the reality of living with the child and with others” (p. 140). This positive view of an element in the *torn asunder* theme demonstrated the variety of interpretations that can be given to an experience.

The emotional turmoil resulting from feelings of nothingness, to frightening thoughts, to feeling normal for periods of time contributed to a Jekyll/Hyde experience within PPD. Beck (1992, 1993) found that women reported they often felt crazy during their depression, one in particular mentioning that her husband “felt like he was living with a Dr. Jekyll and Mr. Hyde”. A participant in my study also referred to Dr. Jekyll and Mr. Hyde to convey her feeling of both being sane and insane with PPD. Beck (1993) identified this as “teetering on the edge, which refers to walking the fine line between sanity and insanity” (p. 44). Walking this fine line was exhausting for women and undoubtedly the most tormenting aspect of PPD.

The violent language used by the participants in my study to describe their experiences and feelings within the *torn asunder* theme is noteworthy. This is a finding that does not appear to have been addressed in previous research literature. Women said that they felt fractured, shattered, scattered, broken, punched, and fragmented by their experience with PPD, illustrating the assault inflicted by this mental health illness. In addition, the wall hanging reflected the violent language in the image of the fractured

heart. This finding would suggest that woman experience PPD as a destructive force that destroys their sense of self.

Safely Home

Safely Home is a theme that illustrated the positive aspect of PPD reflecting women's reports of having learned and grown from the experience. This has not been the focus of previous research and few investigators made note of the recovery in their work. Beck (1993) stated that even when women recover from PPD, it leaves "an indelible mark on mothers' lives" (p. 47); women feared the depression's return although were, in fact, fully well again. Mauthner (1999) noted in her qualitative study of women's experiences of motherhood and PPD that one participant learned to be more accepting of herself as a result of the depression.

In contrast to the lack of studies on the positive aspect of the depression, the women in my study were very vocal about this part of the experience. The personal growth or perhaps healing elements of their experiences were evident on the wall hanging as all participants' squares display hearts and symbols representing the love and hope integral to their healing. They were adamant that they learned a great deal about themselves and were now stronger for their journey through PPD.

PPD is a phenomenon that has caused great trauma to women and their families.

However, despite this, the participants found that the experience enhanced their self esteem and helped to re-establish their priorities. One woman stated: "It will always walk with me and I always want it to because that's a part of me that has a lot of gifts to give".

The contradiction of suffering with PPD but being thankful for the experience is an intriguing aspect of the lived experience of PPD.

Limitations of the Study

My research contributes to the breadth of knowledge about PPD in a number of ways. It is, however, limited to descriptions provided by four Caucasian women in stable relationships at the time of their depression. All represented Canadian middle class demographics. The conversational interviews provided an opportunity to generate rich descriptions and develop an in-depth understanding of PPD, but, due to the small sample size and hermeneutic methodology, the findings cannot be generalized.

Implications for Nursing Practice

My study investigated the lived experience of postpartum depression for four women. Their experiences both confirmed and expanded prior phenomenological research literature. Implications of this study for nursing practice will be revealed in a discussion regarding previous PPD research findings as they relate to the experiences of the participants.

All participants in my study revealed a previous history of depression or anxiety, the strongest contributing factor to PPD development (Baker et al., 2002; Beck, 2001; O'Hara & Swain, 1996; Robertson et al., 2004). They also stated that the onset of PPD was unexpected and initially they were unaware that their symptoms were indicative of PPD, which is consistent with finding in other research (Baker et al., 2002; Dennis & Ross, 2006; Ugarizza & Schmidt, 2006). This evidence suggests that increased education strategies are warranted. Nurses in contact with depressed young women should provide anticipatory education about their increased risk of postpartum depression. A participant in the focus group stated that her health provider had forewarned her that menopause

could be a challenge for her due to her low hormone levels. This type of biomedical knowledge is helpful for all women.

Research has revealed a wide range of symptoms that are indicative of PPD, including fluctuating emotions, feeling overwhelmed, anxious, sad, inadequate, guilty, having frightening thoughts about the baby, and decreased interest in pleasurable activities (Beck, 2005; Flynn, 2005; Hanley, 2006; McIntosh, 1993; Morrow et al., 2008; Williamson & McCutcheon, 2007; Urgarriza & Schmidt, 2006). Participants in my study struggled with all of these, yet most did not associate them with PPD. While each had a unique experience of the depression, the individual symptoms were well identified in the research literature. This information must be disseminated to women and their families so they will recognize the warning signs and access support services in a timely fashion.

Nurses have an important role to play in educating women and their families about PPD. Most women come in contact with their public health nurse or home visiting nurse at the end of the pregnancy or after delivery when any opportunity for anticipatory education is past. Some prenatal classes offer PPD education but the participants' attention is usually focused on labour and delivery. There is an opportunity for the development of nurse prenatal clinics which would screen women for PPD, provide information about the signs, symptoms and preventative measures of PPD for men and women, discuss the transition into parenthood, and provide education about realistic expectations of the postpartum period. Nurses must also discuss the effects of PPD on children and the protective aspects of at least one parent remaining mentally well. If appropriate, both parents would attend the appointment to better prepare for their new life and support one another through the transition.

PPD has a negative impact on women, their children and their families (Baker et al., 2002; Horowitz & Cousins, 2006; Posmontier, 2008; Williamson & McCutcheon, 2007). Breastfeeding is affected (Hatton et al., 2005; Henderson et al., 2003), as are relationships (Baker et al., 2002; Williamson & McCutcheon, 2007). The most serious impact is the growing incidence of maternal suicide (King et al., 2004; Ratnaik, 2006). Partners of depressed women are at higher risk for developing depression themselves (Goodman, 2004) and their children may suffer profound and long lasting effects (Buist, 2006; Edhborg et al., 2001; Hanley, 2006; Horowitz & Cousins, 2006; McMahon et al., 2006; Murray, 1992; Murray & Cooper, 1996; Stanley et al., 2004).

Two of the four participants in this study discussed the severe strain of PPD on the relationship with their partner. One said that she was surprised the marriage survived. Two said that their partners probably also struggled with depression, which supports previous research findings. Both earlier research and corroborating evidence from this study suggest that the whole family needs education and support as well as the mother besieged by PPD. Nurses who provide postnatal home visiting services must include the mother's partner when discussing PPD and its effects on the family. It is my experience as a public health nurse that the mother is usually assessed for signs of depression yet rarely is the partner assessed. Because evidence has shown that the influence of a mentally healthy father may protect the children from the deleterious effects of the mother's depression it is important that nurses support the whole family (Edhborg et al., 2001). Nurses must also provide anticipatory education regarding the long term lingering effects of the depression for some women and encourage women to seek help and support even in recovery.

Many communities offer universal screening for depression. Perinatal screening for depression has been shown to be a valid method of ensuring early identification and treatment (Buist et al., 2002; Hanna et al., 2004). Vancouver Island Health Authority; Child, Youth & Family Community Health nurses (aka public health) offer the Edinburgh Postnatal Depression Scale (EPDS) (Cox et al., 1987) to all postpartum women at the two and six month immunization appointments. In addition, all British Columbia midwives and physicians offering maternity services are encouraged to screen pregnant women between 28 and 32 weeks' gestation (BC Reproductive Mental Health Program & BC Ministry of Health, 2006).

Three women in my study who were offered the EPDS found it to be “useless”. It did not reflect their experience or identify their symptoms as depression, which resulted in a delay in treatment. Beck (1992) underlined this concern with the EPDS and called for “methodological research focused on developing a quantitative instrument to measure postpartum depression specifically” (p. 170). Beck and Gable (2000) developed the Postpartum Depression Screening Scale (PDSS) but, as it has 35 items in contrast to the 10 item EPDS, it takes more time and is more complex to complete. In addition, the PDSS is a cost item (Western Psychological Services, n.d.) while the EPDS is free. Research on the EPDS has indicated that it has adequate sensitivity and specificity (Cox et al., 1987) but screening tools are only as effective as the health practitioner using/providing them. It is vital that nurses use screening tools as an adjunct to nursing judgment rather than the primary diagnostic instrument. The assessment is not complete until a woman is asked if her score is an accurate reflection of her mental state. Nurses possess the clinical judgment to probe further when they sense a client is not well.

Researchers have shown that prevention of PPD is very difficult; it remains very difficult to measure the depression that was prevented. Tactics include early educational strategies (Beck, 1998; Dennis & Ross, 2006; Ogrodniczuk & Piper, 2003; Zlotnick et al., 2006), early debriefing strategies (Dennis & Creedy, 2004; Ogrodniczuk & Piper, 2003), and alleviating risk factors such as sleep deprivation (Dennis & Ross, 2005). However, at the population level women exposed to preventative strategies have been shown to develop PPD at the same rate as women without these interventions (Dennis & Creedy, 2004).

Treatment of PPD has been thoroughly investigated. Effective options include pharmacological therapy (Buist, 2006; Davies et al., 2003; Grigoriadis & Ravitz, 2007; Hanley, 2006; Horowitz & Goodman, 2005; Ugarizza & Schmidt, 2006), Cognitive-Behavioural Therapy (Corral et al., 2005; Hanley, 2006; Highet & Drummond, 2004; Milgrom et al., 2005), Interpersonal Therapy (Buist, 2006; Corral et al., 2005; Grigoriadis & Ravitz, 2007; Horowitz & Goodman, 2005; McQueen et al., 2008; O'Hara et al., 2000; Reay et al., 2006), non-directive counselling (Highet & Drummond, 2004; Milgrom et al., 2005), and support group attendance (Heh et al., 2008; McQueen et al., 2008). The study participants sought help for their PPD and all received anti-depressant medications. This was effective for three of the four women; one found that the undesirable side effects outweighed any benefit so she took only one dose. Another attended a support group facilitated by public health nurses and found it extremely helpful. Another, after three sessions of non-directive counselling was pronounced healthy again, though she herself did not perceive improvement. Some time later, she received anti-depressant medication and found immediate and profound relief from her PPD symptoms. The implication is

that once PPD is diagnosed, treatment is possible. The findings of my study show that not all treatments are effective for all women; both the woman and health professional must persevere to find the appropriate and effective treatment.

Nurse researchers have identified one of the most effective treatments for PPD is nurse led non-directive counselling at postnatal home visits (Davies et al. 2003; Dennis & Creedy 2004; Dennis & Chung-Lee, 2006; Hanley, 2006; Ugarizza, 2006). Women found that it was very helpful to talk to nurses who provided a non-judgmental and knowledgeable presence. Some areas have developed programs whereby women at risk of developing PPD are provided a predetermined number of 'listening visits' by public health nurses (Munro & McIntee, 2005). Any area offering the Edinburgh Postnatal Depression Scale (Cox et al., 1987) screening tool to women should have a nursing 'listening visit' program to support those who are at risk for this depression.

Nurses are often involved in the facilitation of support groups, which have been shown to be effective in the treatment of PPD (Heh et al., 2008; McQueen et al., 2008). Not only has artistic representation of a phenomenon been shown to be a powerful form of data collection for research, nurse researchers have also demonstrated the efficacy of art as therapy (Perry, Thurston, & Osborn, 2008). Nurses could offer support groups for women with PPD and provide materials for artistic expression. My study has demonstrated that the creation and sharing of art is an effective method for encouraging dialogue about women's experiences with PPD. As a PPD support group facilitator I have noticed that many women feel uneasy when they first attend the group. A creative project may decrease awkwardness, increase fellowship, understanding and dialogue, and contribute to recovery.

In addition to fostering creative activities, nurses facilitating PPD support groups could incorporate a physical component to their sessions. The women in my study demonstrated an increased desire to exercise, which decreased their depressive symptoms. Nurses could lead a stroller walk during the support group and the participants would benefit physically and emotionally. There are many opportunities for nursing creativity in the support of women with PPD.

Nurse could also facilitate PPD support groups for either both parents or just partners. Despite research demonstrating a high percentage of depression in men there are few supportive services directed to them. It is time that this changed and that nursing focus includes the whole family.

A variety of research methodologies have been utilized to study PPD. Ethnographic narrative, (Morrow et al. 2008), grounded theory (Beck, 1993; Edhborg et al., 2005) and phenomenological (Barr, 2008; Beck, 1992; Nicolson, 1999) approaches have increased knowledge regarding this phenomenon. PPD lends itself to examination through differing lenses because so many factors influence onset and recovery. A range of research approaches need to be used to study PPD so that a comprehensive picture of this illness can be developed, understood, and publicized.

Directions for Future Research

Using an interpretive approach to understand the essence of PPD, participant art was collected as data. The fabric pieces offered another opportunity for the participants to express their experiences and it seemed as cathartic and healing for them as it was enlightening for me. I would like to see further research about PPD utilizing art as data. Participants in my study felt strongly that the profile of PPD must be raised in our society

so that women and families are more quickly and appropriately diagnosed, treated and supported. A participatory action research methodology utilizing artistic representations of women's experience would be a powerful tool for further investigation.

Participatory Action Research can be utilized to challenge social customs and assumptions (Chenail, St. George & Wulff, 2007). For example, it would be an ideal methodology with which to question the presumption that the experience of motherhood is always joyous and without stress. One product of such research could be an artistic exhibit like the AIDs quilt or a photo novella of women's postpartum experiences which could colourfully and dramatically raise public awareness and understanding about PPD and the transition to parenthood. The women in my research study were enthusiastic about their artwork; it is possible that further PPD research using artistic data would be both exciting and edifying for those who volunteer to participate. The healing properties of engaging in an artistic representation of PPD could also be investigated.

Another revelation in my study was that so many men are adversely affected by their partner's PPD. Two of the four women suspected their partners also suffered with depression. A literature search on men and postpartum depression uncovered little research; only one nurse researcher used phenomenological methodology to interview seven men about their experience with their spouse's or partner's PPD (Roehrich, 2007). This kind of depression in men must be thoroughly investigated to better understand men's experience.

A further insight of my study was the unresolved feelings that all my participants experienced despite stating that they had recovered from the depression. They voiced some trepidation and difficulty in creating their squares, some crying in the process.

There are few longitudinal studies about the long term experience of PPD. It would be useful to investigate this aspect of the depression to better understand women's experience of PPD over the long term.

Conclusion

My study investigated the lived experience of postpartum depression, its undergirding theoretical framework being Heidegger's interpretive phenomenology (Wojner & Swanson, 2007). Researcher and participants entered into dialogue to understand the essence of the phenomenon. Researcher biases and assumptions were an integral part of the interpretive approach (Crist & Tanner, 2003; de Witt & Ploeg, 2005; Mapp, 2008; Penner & McClement, 2008).

Four women discussed their experience with PPD in an open, conversational interview in addition to drawing, painting and sewing a visual representation on fabric. A focus group was held after initial data analysis had been completed and the fabric squares sewn into a wall hanging. Further data analysis was undertaken; exemplars and paradigm cases were identified (Crist & Tanner, 2003; Leonard, 1994). Three themes emerged: *cast adrift*, *torn asunder*, and *safely home*. Four elements contributed to the theme of *cast adrift*: a) feeling lack of control: feeling b) feeling abandoned, c) feeling disappointed, D) feeling fearful and worried. These describe a woman's PPD journey when she feels that she has no control over the course of the illness, feels misunderstood and unsupported by those she would most expect to depend on, feels disappointed in them and in herself, and feels worried about her infant and her future. *Torn Asunder* encompasses two elements: a) loss of identity and, b) loss of sanity. This theme represents the violent assault on

women's self-concept and the frightening thoughts that many experience. *Safely Home* describes the resolution and positive outcome of the illness.

The findings of my study contribute to knowledge about the lived experience of PPD and the usefulness of utilizing art as data. Further phenomenological research incorporating visual representations of women's and/or men's experiences is recommended in order to increase understanding and raise awareness of postpartum depression. Increased awareness of partners' experiences and a longitudinal study of women's experience with PPD are also recommended.

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Appendix B: Participant Consent Form

FACULTY OF HUMAN AND SOCIAL DEVELOPMENT

**DEPARTMENT OF NURSING
FORM**

PARTICIPANT CONSENT

THE LIVED EXPERIENCE OF POSTPARTUM DEPRESSION

AS REFLECTED IN FABRIC ART

You are invited to participate in a study entitled “The Lived Experience of Postpartum Depression as Reflected in Fabric Art” that is being conducted by Hilary Planden.

Hilary Planden is a graduate student in the Department of Nursing at the University of Victoria and you may contact her if you have further questions by calling her at (250) 652-5259 or emailing her at rplanden@shaw.ca.

As a graduate student, I am required to conduct research as part of the requirements for a masters degree in nursing. It is being conducted under the supervision of Dr. Elizabeth Banister. You may contact my supervisor at (250) 472-4703.

The purpose of this research project is to gain a better understanding of women’s experience with postpartum depression. Much of the research done in this area results in written papers. This research will result in a written thesis in addition to a visual representation in fabric of women’s experiences with postpartum depression. It is the hope of the researcher that the resultant hanging will be displayed in a public location in order to raise public awareness of this illness.

Research of this type is important because health professionals, women and their families will benefit by a more thorough understanding of women’s experience of postpartum depression. This research will enhance health professional’s knowledge and understanding of this illness so that programs and initiatives will be developed to support women and their families who have been affected by postpartum depression. The public display of fabric art symbolizing women’s experience with postpartum depression will

increase society's knowledge regarding the illness. Therefore, women will be encouraged to seek support and treatment in a more timely fashion, thus decreasing the incidence of chronic depression and subsequent postpartum depressions.

You are being asked to participate in this study because you responded to the ad posted in fabric stores, recreation centres and libraries in Greater Victoria. You may also have heard of this study from friends or acquaintances. In either case, you called the researcher who gave you the details of the study and the commitment required by your participation. You have identified yourself as someone who experienced feelings of depression or sadness after the birth of your baby. Additionally, you have identified yourself as someone who enjoys working with fabric and who would be interested in creating a visual representation of your postnatal experience.

If you agree to voluntarily participate in this research, your participation will include participating in three interviews and creating a 2 foot square fabric visual representation of your experience with postpartum depression. The first interview will take approximately half an hour and will be a brief outline of the research project and details about the fabric art. It will take place at a mutually agreed upon location and will be audio-recorded. You will be able to create the fabric art by whatever means suits you, whether it be sewing, painting or gluing. You are free to use your own fabrics and materials or I will provide up to fifty dollars for the purchase of materials in order for you to fulfill this part of the project. Once you have finished your fabric square, and no more than one month from the initial interview, you will meet again with the researcher to discuss your artwork and how it reflects your postnatal experience. The interview will take the form of an open ended conversation. It will take place in a mutually agreed upon location and will be audio-recorded. It will take approximately an hour and a half but no longer than two hours. Within one month of the interview you will be required to attend a focus group with the other four participants in this research study. The location will be somewhere that is easily accessible such as a recreation centre meeting room. The focus group will take approximately an hour and a half. By the time the focus group convenes I will have created a wall hanging out of the fabric squares; this wall hanging will be the focus of the discussion. You will be asked how the fabric art represents your postnatal experience. The resulting conversation will be audio-recorded. In addition, a fellow grad

student will take notes to augment the audio-recording. This focus group will serve to validate my initial understanding of the participants' experience with postpartum depression in addition to encouraging further discussion of the experience. The final wall hanging will be publicly displayed, perhaps in the Victoria General Hospital, a recreation centre or public library

Participation in this study may cause some inconvenience to you, including the time commitment of participating in the two individual interviews, the focus group and the amount of time spent creating the fabric art.

There are some potential risks to you by participating in this research and they include feelings of stress or anxiety caused by revisiting a challenging period in your life. To prevent or to deal with these risks the following steps will be taken. Before the interviews begin, you will be assured that, should you become upset, you will be able to take a break, end the interview and reschedule it later or withdraw from the research study altogether. If you become upset during the individual interview, I will offer to turn the audio-recorder off and debrief with you. At the beginning of the focus group you will be assured that you can withdraw from the discussion at any time and that your data will not be used should you request it. If you become upset during the focus group, I will offer to turn the audio-recorder off and give you the opportunity to leave the group. You are not required to stay should you wish to leave. I will provide a list of counseling services to you if requested.

The potential benefits of your participation in this research include personal benefits, benefits to society and benefits to the state of knowledge. The personal benefits include the opportunity to debrief a period in your life that may have been challenging and that your family or friends may not feel comfortable discussing with you at the time or in the present. A benefit to society is a greater understanding of the experience of postpartum depression. Postpartum depression has been shown to have an adverse effect on the growth and development of the children of affected women. It also interferes with the attachment between mother and child. Society depends on healthy youth to be the future leaders of tomorrow. Thus, a greater understanding of postpartum depression will encourage early treatment and contribute to the development of healthy productive

families and future adults. Finally, a benefit to the state of knowledge is the fact that an increase in knowledge about postpartum depression will assist governments and health professionals to design programs and treatment that support women and their families who are struggling with the illness. In addition, the emphasis on artistic representation in this research study may encourage researchers to investigate nontraditional research methods.

As a way to compensate you for any inconvenience related to your participation, you will be offered fifty dollars with which you can buy materials to create your fabric square. You may also use your own materials, should you prefer. If you agree to participate in this study, this form of compensation to you must not be coercive. It is unethical to provide undue compensation or inducements to research participants. If you would not participate if the compensation was not offered, then you should decline.

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. If you withdraw after the focus group, any data that is attributed to you will be omitted from the analysis. You may keep your fabric art and any financial compensation provided to you.

To make sure that you continue to consent to participate in this research, I will review the consent process prior to each interview and the focus group. The benefits and risks will be reviewed as will be confidentiality. The research process will also be reviewed and you will once again be assured that your participation is completely voluntary; you will be able to withdraw at any time without consequence or explanation. You will be asked again for permission to display your fabric art. All the information will be in letter form which I will review with you orally. I will answer any questions or concerns that you may have. At this time you will be asked to sign the consent letter again.

In terms of protecting your anonymity I will support your use of a pseudonym during the focus group. Prior to the focus group we will discuss the name you wish to be called. Your fabric art will be unsigned and no identifying information will be on it unless you wish to identify yourself. The analysis of the data will not include any identifying information.

Your confidentiality and the confidentiality of the data will be protected by the use of pseudonyms. Any identifying information (place of work, family names etc) will be altered for the purposes of the research paper. The interview tapes and transcripts will be kept in a file cabinet in my home. After the research paper has been written and approved, the tape and transcripts will be destroyed. Your name will not be on your artwork unless you wish to identify yourself. The only circumstance where confidentiality would not be protected would be if you revealed intent to do self harm. If that were to happen I would immediately call emergency mental health services.

It is anticipated that the results of this study will be shared with others in the following ways. I will present my findings in a thesis presentation and I anticipate a copy of the thesis to be available in the University of Victoria library. I will also offer you a copy of the thesis. In addition, the wall hanging will be displayed in a public venue frequented by women and their families such as a recreation centre, library or hospital.

Data from this study will be disposed of by shredding both audio-tapes and any paper transcripts or records once the thesis has been accepted and approved.

Individuals that may be contacted regarding this study include researcher Hilary Planden at (250) 652-5259 and Hilary's supervisor Elizabeth Banister at (250) 472-4703.

In addition, you may verify the ethical approval of this study or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca).

Your signatures below indicate 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 researcher.

Name of Participant

Signature

Date

Name of Participant

Signature

Date

Name of Participant

Signature

Date

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Appendix C: Fabric Wall Hanging

