The Lived Experience of Becoming Herself Through Postpartum Depression

by

Monica Ann Sager
RN, Vancouver General Hospital School of Nursing, 1989
BSN, University of Victoria, 1991
MN, University of Alberta, 1996

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We accept this thesis as conforming to the required standard

Dr. Norah Trace, Supervisor (Dept. of Educational Psychology and Leadership Studies)

Dr. Geoffery G. Hett, Co-Supervisor (Dept. of Educational Psychology and Leadership Studies)

Dr. Joe Parsons, Outside Member (University of Victoria Counselling Services)

Dr. Antoinette Oberg, External Examiner (Dept. of Curriculum and Instruction)

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University of Victoria

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Drs. Norah Trace and Geoffrey Hett

ABSTRACT

The purpose in this study was to investigate the lived experience of PPD and what helps mothers during this time. An estimated 10-15% of women who give birth will experience postpartum depression. My goal was to expand current information and knowledge available in the area of PPD, and to share women's experiences of living with PPD so that the commonalities of the experience could be noted and the stigma lessened and hopefully removed. Since little empirical knowledge exists on the lived experience of PPD a qualitative research approach was employed to answer the research question. The findings indicated that the lived experience of PPD seems to parallel that of women's identity development. The length and severity of PPD seem associated with identity development. The women in this study work through the process of recovery. This process is captured in the framework *Becoming Herself Through Postpartum Depression.* Initially, they worked from a place of being a self for others, to losing her sense of self during the pit of the depression, to coming out of this deep depression as she uncovers her sense of self, and becoming settled in a place where she has found her sense of self and recovered from PPD. For some women, they may reach a place of contentment and peace with earlier life challenges, and discover that they no longer live with fear should they become depressed again in the future.

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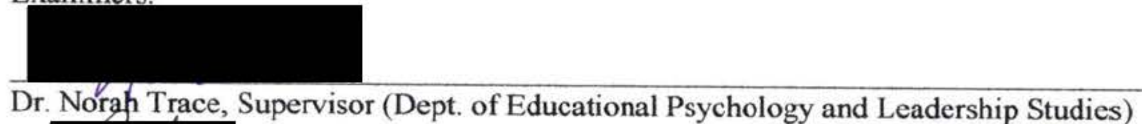

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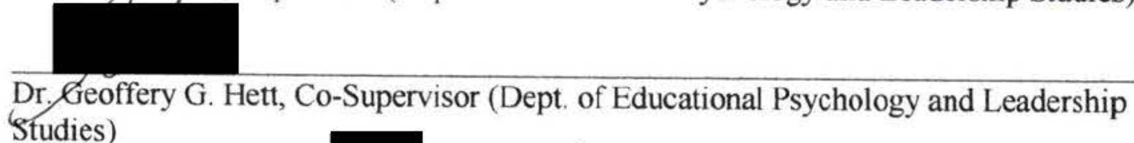

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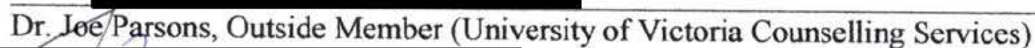

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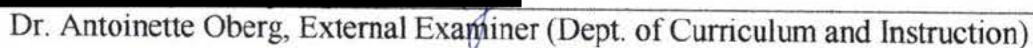

Dr. Antoinette Oberg, External Examiner (Dept. of Curriculum and Instruction)

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This study would not have been possible without the support, encouragement, and wisdom from many incredible human beings.

First, to the women who bravely volunteered to share their stories of labouring, mothering, and finding themselves postpartum, so that other women who have had, are presently living with, or who may have PPD in the future may benefit from your wisdom and courage. By your strength in adversity, the stigma presently associated with PPD and the length and severity of PPD may be significantly diminished for women in the future.

Second, I would like to express my sincere appreciation to the members of my thesis committee. To my supervisors, Dr. Norah Trace and Dr. Geoff Hett for their unending support and encouragement throughout this research study. In particular, I would like to thank Dr. Norah Trace for sharing her wisdom and expertise with PPD; and, Dr. Geoff Hett for being a strong pillar for me in uncertain times and for facilitating the process to have this thesis completed in a timely manner. Dr. Joseph Parsons, a member of my committee, for his attention to detail, continual support, sense of humour, and flexibility with regard to helping me accomplish this thesis in time. Dr. Antoinette Oberg, my external examiner, for her insights and expertise on qualitative research.

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Finally, the most important people in my life, my dear family and friends, who were with me while I lived with PPD and who helped me work through and complete this research. In particular, I want to thank Peter for believing in me and sticking with me every step of the way while I was finding myself. For Alanna, who helped me to become the strong woman I am today, and for Liam whose gentle spirit replenished me. Thank you from the bottom of my heart, and God bless.

DEDICATION

To Sandy … who sat with Me

FINDING HERSELF THROUGH POSTPARTUM DEPRESSION

How might your life have been different, if, when you were a young woman, the first time you felt feelings of depression, an older woman had come to sit with you? If she had come to sit with you, as someone had come to sit with her the first time she had feelings of depression? To simply sit, quietly, perhaps wordlessly –to sit with you, during your dark time.

And how might your life have been different if the woman had accepted your feelings of depression? Had accepted them so completely and fully that you began to feel safe with them. If there had been no judgment and no questioning… no attempt to make you smile, to betray your feelings, to deny your darkness. If the woman had simply sat in silence with you, with your pain, and in the darkest moments had been able to reflect it to you…to reflect to you your pain…to witness…attend…and by her quiet respect for it, to help you learn to respect it…your own pain and depression…to witness, attend and respect your depression…and to see that just as the woman had faith in it, you also might have a glimmer of faith that there was meaning and truth in you darkness.

How might your life be different? (p. 35)

Source: Duerk, J. (1989). *Circle of stones: Woman's journey to herself.* San Diego, CA: Luramedia.

I. INTRODUCTION

A Place To Begin

Statement of the Problem

Why is it that some women become depressed following the birth of their child? The suggestions are many; the answers are few. To date, an estimated 10-15% of women will develop postpartum depression (PPD) in the first weeks after delivery (Epperson, 1999; Steiner & Tam, 1999). This statistic appears conservative once a historical perspective is considered. History tells us that more mothers will experience depressive episodes within the first year postpartum.

In 1838, Esquirol, a French psychiatrist, recognized that mild to moderate psychiatric disorders were 'common' in patients following childbirth (Esquirol, cited in Cox, 1989). However, detailed information was not recorded until 1858 when his successor, a French psychiatrist named Marce, wrote the first research paper entirely devoted to PPD (Cox, 1989; see also Taylor, 1989). It would be one hundred years later before PPD would be studied more scientifically. In 1960, between 3-6% of women were diagnosed with PPD (Affonso, 1992; Perry, 1993). This figure tripled to 10-15% in the 1980s (Cox, 1989; Kumar & Robson, 1984; Misri, 1989), and doubled within a decade to 20% in the 1990s (Affonso, 1992; Dobie & Walker, 1992; Misri & Duke, 1995; Pacific Post Partum Support Society [PPPSS], 1997; Perry, 1993; Sweet, 1996). However, it is important to note the lack of congruency amongst authors on the incidence of PPD in the 1990s.

Some authors (Jermain, 1992; Lepper, DiMatteo, & Tinsley, 1994; Nalepka & Coblentz, 1995; O'Heron, 1991; Stamp, Williams, & Crowther, 1996; Stowe &

Nemeroff, 1995; Warner, Appleby, Whitton, Faragher, 1996) report an incidence as low as 10-15% for this decade, and others (Griepsma et al., 1994) report an incidence as high as 58%. It is my contention, however, that the incidence of PPD is as high or higher than 58%. The incidence of unreported cases could account for this variability. According to Whitton, Warner, and Appleby (1996), over 80% of women who suffer from PPD will not report their symptoms to any health caregiver.

Inarguably, there is a need to research this issue further; despite whether, for instance, this recognition is associated with an increase in our awareness over the decades or our ability to detect women at risk. However, the question still remains: Why is it that some women become depressed following the birth of their child? Would changing how we call this period in a woman's life make a difference in the number of reported cases of PPD? Rather than calling this PPD, is there a more appropriate way to label this phase or developmental period in a woman's life? When I ask myself how can I best understand why women become depressed postpartum, I find myself feeling compelled to go directly to the very women who have had or are presently experiencing PPD. I have often pondered: What was it like to live with PPD? What has this process meant? And, what seemed to help at that time?

Purpose of the Study and Research Question

The purpose in this study was to determine what is it like to experience PPD, and to determine what helps women to live through this experience. By conducting this study, our knowledge of PPD would increase and could lead to five benefits: 1) an appreciation of what it means to live with PPD; 2) recognition of who may be at risk; 3) a greater understanding of why some postpartum women do not experience PPD; 4) an

appreciation for why some women experience PPD for much longer periods than others; and 5) strategies to lessen the intensity and shorten the duration of the experience for women and families living with PPD. The principal research question was: What is the lived experience of finding herself through postpartum depression?

Personal Stance

My journey with PPD began about nine years ago after my daughter was born. However, thoughts of what it was like for me to live with PPD only came consciously to mind two years later when I was asked, by friends and family who were concerned for others presently living with PPD, about my experience and what I did to get through it. I believe that I subconsciously chose not to reflect on my experience of PPD before this time as I was protecting myself from becoming vulnerable yet again and falling back into the pit of darkness. However, I became preoccupied and concerned for the women who were presently living with PPD and wanted to help. I offered to research this further to discover what may help, as I intuitively knew that what helped me may or may not help another. Around the same time, I was asked by my professor, who was teaching a women's health issues course, to write about my experiences as there was virtually no empirical research conducted in this area. Although I began researching PPD and recording my own personal experience with PPD at that time, it would be six and a half years later before I could hear others' stories of PPD that were different from my own. I felt angered and questioned how anyone could call their experience PPD when it seemed not nearly as severe or inconsistent from what they expressed earlier in their postpartum recollections. I wondered if it was becoming a 'catch all' phrase to gain attention and or sympathies from others. For instance, someone complaining of a migraine when really it

is likely just a headache. The stories seemed different from how I had come to know what PPD was. Perhaps then, it was more about my own process of coming to terms with my experience of PPD, whereas now, I feel more accepting, open, and curious about others' experiences.

Since my journey began my conceptualization of PPD has evolved. I believe this was a result of my own experience, intense emotions, and questions surrounding the phenomenon of PPD. I have found that the process of writing about PPD has helped my conceptualizations of PPD to evolve. I have written papers on PPD from a variety of perspectives (my own experience; a medical versus feminist perspective; a postmodernist perspective; a cross-cultural perspective; and from a cross-generational perspective). What I have learned is that there will always be an inextricable wealth of stories from women who have lived with PPD that will be similar and different from my own. As the years have passed, I find I have more questions than answers, however, I finally feel open to the experiences of others which may be similar or different from my own. It is my hope that the following stories, thoughts and reflections, will bring the reader closer to a richer appreciation and understanding of what it means to live with PPD.

Organization of This Thesis

I do hope that I have come closer to uncovering some of the answers to the above questions after having "conversations" (Bergum, 1989) with women who expressed having PPD. By utilizing Max Van Manen (1998)'s work on hermeunetic phenomenology and Ely, Vinz, Downing, and Anzul (1997) work on writing qualitative research as guides, I have tried to distill the essence of what it means to live with PPD from shared experiences with the four women I have met.

This thesis is arranged in five chapters. In Chapter One, the statement of the problem, purpose of the study, research question, and personal stance is delineated. Chapter Two comprises the methodology of how this research was implemented; an outline of the research design and guidelines used to approach this study are included. In addition, the steps taken for sample selection, data collection, data analysis, reliability, validity, and ethical considerations are outlined.

The findings from this study are presented in Chapter Three. Within that chapter, the characteristics of the sample are described, and the four women who were interviewed for this study are introduced. The findings from this study are divided into two sections. Part One outlines the variables which set a woman more at risk for developing PPD. These variables are *foundational challenges, triggers,* and *emotional precursors.* Part Two describes the lived experience of PPD. This process of living with postpartum depression is explained through a framework entitled *Becoming Herself Through Postpartum Depression.* This framework was developed in order to connect the experiences of the four women I interviewed, and also to attempt to explain why some women experience PPD for much longer periods than others. Each section is supported with extensive quotations from the experiences of each of the mothers.

Instead of having a separate chapter exclusively for the literature review, relevant literature to the research question will be used as a comparison for aspects of the stories shared to highlight the similarities and differences from what is presently known about PPD. It is my intention "to weave in related literature as a conversation with (my) findings and not as an isolated and often meaningless chapter near the beginning" (Ely et al., 1997, p. 146) of the thesis.

In Chapter Four, the findings are discussed utilizing relevant literature to support the conclusions. In Chapter Five, the implications of the findings for counsellors, psychologists, and other health care providers are given with respect to practice, education and suggestions for further research.

II. METHOD

Attaining Her Story

"Whoever is searching for the human being first must find the lantern" (Nietzsche, cited in Van Manen, 1998, p. 4). Nietzsche was referring to an aphorism by Diogenes, a Greek philosopher from the fourth century BC who used pantomimic gestures to challenge the moral intellect of his fellow citizens and to set an example for how to live. In this example, Diogenes was walking through the streets holding a lantern up in broad daylight proclaiming, "'Even with a lamp in broad daylight I cannot find a real human being,' and when people pointed to themselves he chased them with a stick, shouting, 'it is real human beings I want'" (p.5). Although humourous, the point being made here, from a phenomenological perspective, is that we need to question the way we experience the world with respect to a specific phenomenon, and then to begin living in that world of the phenomenon in question, if we are to gain a greater appreciation for what it means to live with that phenomenon. In other words, phenomenology is first appreciated as a philosophy that is interested in the "theory of the unique" (p.7) –meaning essentially, that which is "essentially not replaceable" (p.7).

The purpose in this study was to determine the lived experience of PPD. Given the nature of the phenomenon, a qualitative research approach was chosen. Since a scientific approach is needed, for the professional community in order to accredit women's stories, my intention is to give a voice to support and validate the stories that have been written and shared by women, who have lived or are presently living with PPD, over the decades.

Before one can begin to capture the essence of what it may be like to live with or experience PPD, exploration into the lives of women with this experience, through their own voices about their unique experience, needs to be considered. To achieve this end, I utilized a qualitative research approach. Personal interviews served as the primary source of data collection and were appropriate since the women were literate and well-informed; therefore, they could provide a thick description about their postpartum experience. I employed Max Van Manen's work as a guide; and philosophically, I felt attuned to the nature of a phenomenological approach which is imperative according to Van Manen (1998).

The researcher's assumptions were: the women were considered the experts of their own experience, their perceptions were based on their personal experiences, and that the knowledge and information derived from the interviews would be holistic, relational, and contextual. The researcher's background knowledge and experience of conducting qualitative research is based on an exploratory, descriptive design that utilized ethnographic methods to examine waterbirths and women's perception of warm water immersion for labour for partial fulfillment of the requirements for the degree of Master of Nursing from the University of Alberta. This experience, together with the aforementioned criteria, information above, and one thesis supervisor's recommendation, lead to a decision to explicate the meaning of PPD using a qualitative research approach.

In this chapter, the methods that were utilized throughout this inquiry will be discussed. To begin, a description of the sample and methods used for data collection and analysis will be given. This will be followed by the measures taken to optimize

methodological rigor through a discussion of how reliability and validity were considered with the ethical considerations that guided the researcher's conduct for this study.

The Sample

The kind of sample selected will ultimately affect the quality of the research. To ensure that a quality sample is selected for a research study, two principles must be considered -- appropriateness and adequacy. Appropriateness refers to participants who meet the 'informational needs' of the study and who are literate and willing to share their experience with the researcher. Adequacy means that a sufficient, quality sample was achieved to ensure 'representativeness' (Morse, 1991). In the following discussion, an explanation of how appropriateness and adequacy were achieved will be given with the methods used to access this sample.

Appropriateness

Appropriateness was achieved by utilizing a purposeful sample. This means that women were selected based upon the needs of the study. More specifically, women were selected if they 'fit' the purpose of the study which was determined by the research question: "What is the lived experience of becoming a mother through postpartum depression?" In addition, snowball sampling, where women nominate other women, was also used (Morse, 1991).

The sample was selected from women who have been living with PPD, or who have experienced PPD in the last five years, and who are residing in Victoria, BC. Women from the University of Victoria Family Housing Community were considered first as the researcher had recently moved from this community and had lived there for four and a half years. A social worker employed with the University of Victoria Family

Housing Community nominated women who she thought would be interested in the study. Since only one woman from this community agreed to participate in the study, women from a Mom and Tots group in a neighbouring parish community were subsequently introduced, by the group facilitator, to the study. Ten women, from this second group, were interested in participating; these women were then given an Information Letter. Six of the interested women had experiences with PPD that dated back more than five years. The other three women who had more recent experience with living with PPD were selected. Four women were chosen for this study. Obtaining the sample in this manner resulted in an adequate depth of information being assimilated to answer the research question appropriately.

Women who were included in this study met the following criteria: 1) had the lived experienced of PPD, 2) were over 18 years of age so that an additional consent from the parent or guardian was not required, 3) were able to speak and understand English in order to answer accurately the researcher's questions, 4) were able to reflect on experience and willing to share this experience with the researcher in an interview, and 5) had recently, within the last five years, experienced PPD.

Adequacy

A sample is considered adequate when sufficient data have been assimilated; it is not assessed by the number of participants, but rather, the degree of relevance, completeness and amount of data obtained (Morse, 1991). To ensure that there were no 'thin' areas within the data, sampling occurred together with data collection and analysis until 'saturation' defined below was achieved. Initially, it was proposed that three to four women would provide an adequate amount of quality data to answer the

research question. In the end, a total of four women were interviewed. Two were presently living with PPD, and two felt they were coming out of their experience. Interestingly, one woman had an experience that was very different from the other three. Although she had a variety of supports in place throughout her perinatal period, she still experienced PPD. Although three to four women were proposed for this study, it was difficult to assess the precise sample size for two reasons: *attrition* and *saturation.*

Attrition. There was one potential participant, from the University of Victoria Family Health Centre, who decided not to be part of the study. After responding to the information letter that was provided, this woman called for more information and left a message on the researcher's answering machine. The researcher promptly returned the call only to receive an answering machine reply at the potential participant's house. A message was left with an invitation to call back for more information if still interested. The potential participant did not return the call. In this case, it was perhaps more of a recruitment problem than 'attrition'.

Saturation. Data collection was then terminated when no new thematic information was obtained. The data were considered saturated because no new themes were discovered while analyzing the transcribed interviews (Field & Morse, 1985). In consultation with one of the thesis supervisors, a decision was made that the four participants had provided a sufficient amount of data for collection to be discontinued.

Access Procedures

Women who were interested in receiving more information about the study contacted the researcher by calling the number provided on the information letter or by having the social worker from the Family Health Centre or group facilitator contact the

researcher to say that they were interested. The researcher then used the process of primary selection, to screen the volunteers. In primary selection, the researcher is able to assess, by conversing with prospective participants, who would likely have the knowledge required and be willing to be involved in the study (Morse, 1991). These two access procedures will now be explicated.

Information Letter. Letters of information (see Appendix A) about the study were made available to the social worker employed with the Family Health Centre at the University of Victoria and the group facilitator at the neighbouring parish community. In addition, extra copies of the letter were placed on the coffee table in the main lounge of both sites for any women who might be interested. The information letter had the researcher's telephone number with a brief description explaining the purpose of the study, participant's role in the study, time commitment if enrolled, and a description of how the information shared would be kept confidential. Interested women contacted the researcher for more information; they were told about the inclusion criteria and the time commitment required for a typical interview session. A typical interview session was described as lasting approximately one hour with the participant telling her story. Potential participants were also informed that a consent form (see Appendix B) would be reviewed and signed, before proceeding on with the audio-taped interview, and only if the participant felt comfortable and had no further questions. When the researcher perceived that the potential participant met the criteria of the study during the telephone conversation and gave verbal consent to enroll into the study, then an appointment was arranged to conduct the interview.

To summarize, there were 11 potential participants. Two were referred by the social worker, but only one of these potential participants decided to join. The remainder contacted the researcher in response to the information letter. Six potential participants were not included as they did not meet one of the inclusion criteria –their experience exceeded the five year maximum. In the end, a total of four women were selected and interviewed.

Data Collection

Data were collected over a 5-week period between May 26, 2001 and June 5, 2001. The methods used to collect data were: personal interviews (conversations), fieldnotes and journaling. Conversations, the primary method of data collection will be discussed first.

Conversations

Van Manen (1998) describes a conversation, from a hermeneutic phenomenological perspective, in the following way:

> A conversation may start off as a mere chat, and in fact this is usually the way that conversations come into being. But then, when gradually a certain a topic of mutual interest emerges, and the speakers become in a sense animated by the notion to which they are now both oriented, a true conversation comes into being.... There is a conversational relation between the speakers, and the speakers are involved in a conversational relation with the notion or phenomenon that keeps the personal relation of the conversation intact.
>
> The art of the researcher in the hermeneutic interview is to keep the question (of the meaning of the phenomenon) open, to keep himself or herself and

> the interviewee oriented to the substance of the thing being questioned.... It has been noted by those conducting hermeneutic interviews that the volunteers or participants of the study often invest more than a passing interest in the research project in which they have willingly involved themselves. (p. 98)
>
> When a conversation gradually diminishes into a series of more and more pauses, and finally to silence, something has been fulfilled. It is the same fulfillment that marks the triumph of an effective human science text: to be silenced by the stillness of reflection—reflection on what has been said and on what remains to be said, even merely with a feeling of gratitude for the profundity achieved in the conversation. And when the conversation finally does sink into silence, it is not empty silence, but a fulfilled silence. The truth, not only of the insight that has been acquired, but the truth of life, the state of being in truth that has been achieved in the conversation, continues to make itself felt, indeed becomes deeper, in the course of this silence. (Bollnow, as cited in Van Manen, 1998, p. 99)

The conversations unfolded as described above. In addition, conversations occurred in the woman's home. At times there were minor interruptions from an older child, but overall the home setting was comfortable and conducive to sharing. Conversations often took place over a hot cup of tea with cookies which also made the meeting more comfortable and seemed to facilitate discussion. The women all seemed comfortable with the researcher and with being tape-recorded which was evident through their non-verbal and verbal communication. Secondary interviews were not conducted as the women's

stories were clear and the data did not need to be clarified. The interviews were all audio-taped, and then transcribed verbatim by the a professional transcriptionist.

Each conversation began by the researcher encouraging each woman to talk about their experiences postpartum. Occasionally, the participants were prompted with the following specific questions:

Tell me about what your child's birth experience was like for you, and then the days following? Did you have any ideas or expectations about this experience?

Were you experiencing any other changes in your life? Stresses?

How would you describe your relationship with your (partner, husband, friend) during this time?

Do you have any cultural traditions about birth or the period following in your family?

Did you feel like you had the kind of support you needed from friends, family, or health caregivers?

What else made a difference for you at this time?

How were the first days after the baby was born for you? Was there a point where your feelings changed?

How long did it seem before "you had yourself back"?

Months or years later after you "survived" this experience, did you ever feel like you may be slipping back into it again?

What makes the experience of PPD different from mothering without PPD or depression in general (if they have experienced depression or mothering without PPD in the past)?

Having conversations ensue in this manner allowed the researcher to acquire pertinent information while yielding large amounts of data. In addition, it likely facilitated each woman to feel more at ease in sharing her personally relevant story. Conversations usually lasted for 90 minutes. *Fieldnotes* and *journaling* were also sources of data collection.

Fieldnotes and Journaling

Fieldnotes supplemented the conversational data and were written immediately following the session so that the most accurate information was recorded. Fieldnote data illustrated the context of the setting, non-verbal behaviours, and commented on remarks that were made, that were considered important, when the researcher was preparing to leave. Fieldnote data were analyzed in conjunction with the conversational data.

Journaling supplemented the fieldnote data. The researcher set aside a journal section for subjective thoughts and thoughts about feelings during interviews. In addition, all the researcher's thoughts and new ideas, regarding the study, were recorded in this journal along with the researcher's personal biases and assumptions. Having a secondary place to record this information was imperative in order to maintain objectivity and to better understand the researcher's influence on the research. A discussion of how the data were analyzed follows.

Data Analysis

Data analysis was conducted concurrently with sampling and conversational data collection. By doing this, new questions or ideas that arose could be asked in subsequent

interviews. The transcribed conversations, fieldnotes, and a journal were analyzed inductively by content analysis as described by Miles and Huberman (1984).

Content Analysis

The goal of conducting *content analysis*, as described by Miles and Huberman (1984), is to express what is described by the group under examination "as precisely as possible, attending to their range and generality and to the local and historical contingencies under which they occur" (p. 19). The goal in this analysis was to provide a rich description of the lived experience of PPD.

Content analysis is conducted in three stages: first level coding, pattern coding, and memoing (Miles and Huberman, 1984). Coding is "the process of identifying persistent words, phrases, themes or concepts within the data so that the underlying patterns can be identified and analyzed" (Field & Morse, 1985, p. 137). In general, coding begins by assigning a specific word (code) to a group of words with a common meaning. In this study, the researcher found 'codes' in the words from each woman's transcript after data collection was started. Next, these codes were divided into key categories. By working with the data in this fashion, coding facilitated data analysis because large amounts of information could be simplified into manageable groups. In addition, large amounts of data can become more meaningful if it is colour coded.

The transcripts for each woman were printed on different coloured paper. This was done for three reasons: 1) to identify the source of the data, 2) to identify the number of participants who commented on a theme or category, and 3) to determine if a category looked like it was heavily quoted, but in fact the category was only based on just one or two sources. After each participant's transcript was assigned a colour, the colour-coded

segments of transcripts were cut and then pasted onto a large index card with the theme labeled at the top. Then, the piles of themes were organized into groups or key categories. Later, some of the cut and pasted segments appeared as quotations in the presentation of the data. A more specific description of how data were analyzed using content analysis follows with examples from one of the transcribed interviews from this study.

First Level Coding. In *first level coding* the purpose is mainly descriptive. Each phenomenon was assigned a code that described its attributes, as the researcher examined the data in blocks. Thirty-nine codes were identified (see Table 1) and then operationally defined. To reach this point, key words were underlined in the transcripts and then isolated to the right-hand side margin. For example, the following segment will illustrate how first level coding was conducted:

> Oh, I know. I went to see my doctor in September, because [sister-in-law] said something to me. I forget when, but I didn't make the appointment to go until September. And my doctor said I just needed exercise, and get out and do more, and that kind of thing, and so I thought okay, I'm just not adjusting to being a mom and I just have to do that. You know, I just have to do it. So I went from September until February on my own again, and it was just horrible. Like I did have depression in September, and I was upset that she didn't give me a medication or send me to see someone. Instead, I felt like she brushed me off and I was upset about it. And I did talk to her about it later, so we worked that out. But anyway, [laugh]. Yeah, so in September I went to see her, and I thought I just need to get my act together here. But I couldn't somehow, you know, I just couldn't seem to meet all the demands. I couldn't take care of myself, and it was

Table 1

Initial Coding for Analysis

Physiology?—depleted, bloodwork
Pregnancy- PH, AGE, Hx D, complications
BE (birth experience)
Pain medication
Antidepressant
Labour medication
C (control)—external (EC) /internal (IC)
EX (expectations)-A (expectations postpartum)
Bonding
Grieving
Intuition
+SP Birth (positive emotional support during birth)
+SP AP FF (+support in antepartum from family/friends)
-SP After (negative emotional support postpartum)
-SP After SO (negative emotional support from significant other postpartum)
-SP Before P (negative emotional support from parent during pregnancy)
-SP After P (negative support from parent postpartum)
-SP After FF (no support from family or friends postpartum)
IS (Instrumental support)
Strategies
PB (mother's perception of birth experience)
PA –family/friends (mother's perception of postpartum experience from family/friends)
LS (losing self)
Stressor-$(financial stressors)/ house (daily upkeep) /new mom (transition)
    -Eustress, nut, colic, family
HO (Herself for others) precipitating factors, influences for , CH?
Sleep
SM (Survival mode)
UH (Uncovering herself)
CH (childhood)
IH (invisible health)
No counseling
RSO (Relationship with significant other)
RP (Relationship with parent)
RF (Relationship with family)
B (boundary issues)
L (Learn from experience?)
D (comparing depression with PPD)
FR (Future research)
FI (Foundational issues)

> getting worse and worse and worse through the fall. And I, okay, my brother and my mom and dad came for Christmas, and my brother even said, you know, something's not right, you know, he said he was worried about me. And like, and if you know my brother, that's just astounding. I mean, he would never say anything. [Laugh.] (Denise)

In the right-hand side margin, the following comments were made by the researcher: 'felt on her own', 'no referral made or Rx given', 'perception being brushed off', 'resource-self reflective/intuitive', 'seasonal changes?', and 'strategy-getting out, see doctor'. After first level coding was completed, then the researcher proceeded on with pattern coding.

Pattern Coding. The second stage of analysis, *pattern coding*, provides potential explanation of the patterns and relationships which the researcher identifies as emerging from the data. These codes are placed into categories of common themes or constructs (Miles & Huberman, 1984). During this stage, codes that were labeled in the first level coding may be renamed as the process of data collection and analysis continued. Therefore, the purpose of pattern coding is to infer and not simply to just reiterate or describe what was originally stated by the participant.

Initially, the key categories seemed to be childhood stories (CH), relationship with their significant other (RSO), and their birth experience (BE). As the analysis proceeded, these major themes became part of key categories. Two major sections contained these categories: the hermeneutic phenomenology of PPD, and strategies for living with PPD. Within the hermeneutic phenomenology of PPD, there were three categories: before the baby, birthing the baby, and after the baby (see Table 2). However, this early conceptualization of key categories also changed to provide a deeper

explanation of what seemed to be happening with the emerging themes. To create more meaning from these emerging themes, common codes were pulled together into themes or constructs.

For this study, the researcher condensed the thirty-nine descriptive codes, from first level coding, into thirty codes. For example, three of the aforementioned codes (CH, RSO, BE) became subtitles. The codes CH and BE became subtitles for the category: foundational challenges (see Figure 2-1). The seven descriptive codes listed as +/-SP, defined as positive and negative supports for the mother (see Table 1), were renamed and coded as either RSO (five of the +/-SP codes), ES (emotional support), or IS (instrumental support –or help with the running of the household). The code RSO became a subcategory for the five stages of *Becoming Herself Through Postpartum Depression.*

Using the previously mentioned transcribed segment as an example, the researcher condensed the code 'felt on her own' and 'no referral made or Rx given', and 'perception being brushed off' into the *Language* and *Perception* categories. The code 'resource-self reflective/ intuitive' became a subtitle of *Movers.* 'Seasonal changes' became a cue for a strategy (using a light timer in the home), and 'getting-out' and 'see doctor' also came under the subtitle of *Strategies.* The third and final level of content analysis, *memoing*, will now be discussed.

Table 2

Initial Conceptualization of Key Categories and Themes

PART ONE: THE HERMENEUTIC PHENOMENOLOGY OF PPD

Before the Baby	Birthing the Baby
Risk factors	Birth experience
Childhood Issues	Expectations
Relationship Issues	Emotional Support
Hegemony	Health care providers

After the Baby

Stressors	*Symptoms of PPD*
$ (Financial) Stress	Fatigue
Previous Commitments	Isolation
Relationship with S.O. (significant other)	Hopelessness
Family/Friends	Dreams of Escaping
HC (Health Care) providers	Crying
Instrumental Support	Anger

PART TWO: STRATEGIES FOR LIVING WITH PPD

Mother
S.O. (Significant Other)
Family/Friends
HCT (Health Care Team)
Community
Miscellaneous

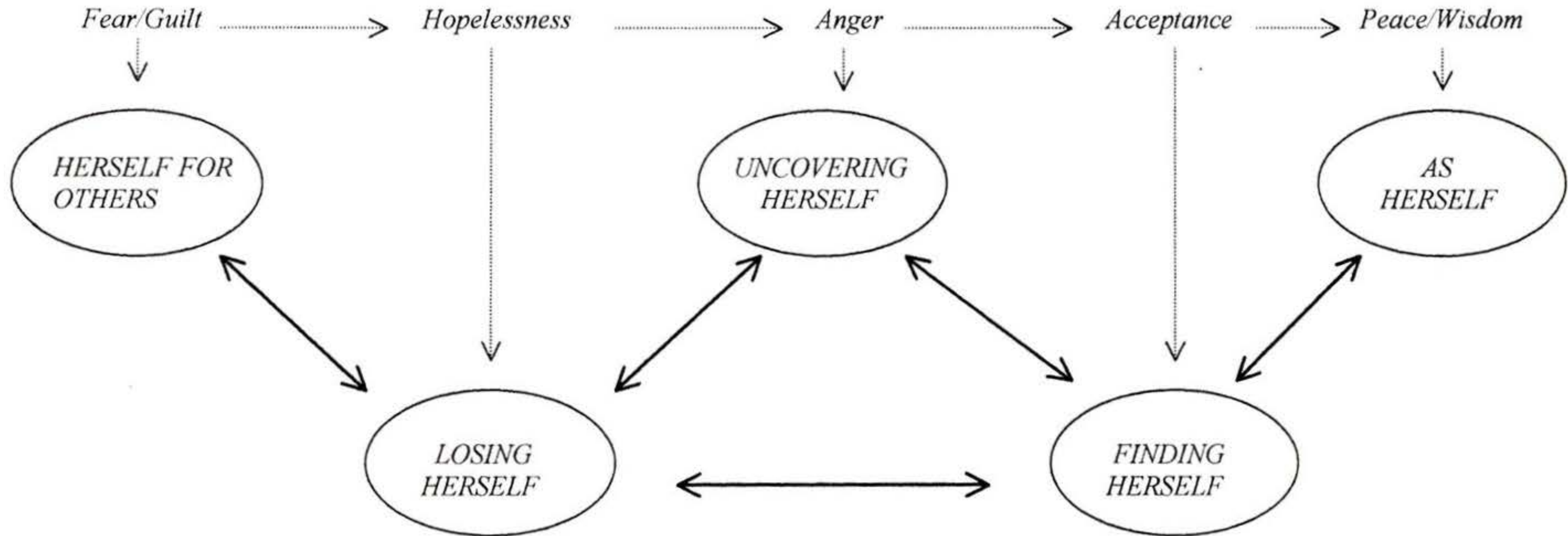
Figure Caption

Figure 2-1. An overview of the framework: *Becoming Herself Through Postpartum Depression.*

BECOMING HERSELF THROUGH POSTPARTUM DEPRESSION

Foundational Challenges: *Childhood Stories, Loss, History of Depression, Mothering, and Birth Experience* **with** *Triggers:* *Colicky/Clingy Baby, Major Life Change, Grave Financial Concerns, Having an Older Child*

Emotional Precursors: Fear and/ Guilt, Hopelessness, Anger, Acceptance, Peace and/Wisdom



Memoing. The purpose of *memoing* is for the researcher to be reflective. *Memoing* involves conceptualizing the emerging themes and relationships (Miles & Huberman, 1984). In this stage, the researcher recorded all insights, interpretations, and linked themes and ideas that emerged from the data. The researcher was able to progress to the conceptual level of analysis. For instance, the thirty pattern codes were organized into eight key categories. Using the same transcribed segment as an example, the researcher organized the category *Language* and *Perception* into the Losing Herself stage. *Movers* became renamed and conceptualized as *Variables to bridge from LH →UH* stage. *Seasonal changes, getting-out*, and *visit doctor* became part of the *LOC-strategies* category within the *Uncovering Herself* stage. To conceptualize emerging themes and relationships, the researcher found it helpful to create a chart on the floor. From here, the index cards with the colour-coded, cut and paste transcripts could be moved around into the eight key categories and corresponding themes. Having the key categories and themes mapped out on a separate sheet facilitated the organization of various thought processes as shown in Figure 2-2.

To conclude, content analysis continued until no new categories or relationships were discovered. The analysis of data provided a rich description of the lived experience of PPD. The results from the analysis will be described in Chapter III, and later discussed in Chapter IV. A summary of the findings from a developmental psychology perspective will be considered in Chapter V. Implications of these findings will be presented in Chapter VI.

Figure Caption

Figure 2-2. A detailed perspective of the stages of *Becoming Herself Through Postpartum Depression.*

BECOMING HERSELF THROUGH POSTPARTUM DEPRESSION: .

A Detailed Perspective of the Stages

ELEMENTS (That Compose Each Stage)	*HERSELF FOR OTHERS (HO)*	*LOSING HERSELF (LH)*	*UNCOVERING HERSELF (UH)*	*FINDING HERSELF (FH)*	*AS HERSELF (AH)*
Definition	Model Wife/Mother	Sad, Lost, Hopeless	'Mother Grizzly'	Reflective	Reflective/Honouring
Language	Emotionless	Negative	Angry	+ and reflective	Reflective, +, Wise
Voice	Denial	Empty	Has energy	Calm	Calm / Laughter
Perception	Hers, and not necessarily shared by others	Negative and hopeless	More positive Considers her affect on others	More positive, encouraging, and forgiving of self	Forgiving, accepting and open to critical reflection from others
LOC (Locus of Control)	Buried	Exposed*	Lean-To**	Shelter	Home
RSO (Relationship with Significant Other)	Avoiding "I'm fine"	Separate "in the doghouse"	Partnership "I'm ok, you're ok"	Couple "We're okay"	Interdependent "us"

*includes universally experienced feelings, by each of the women, while living with PPD and is related to their ↓ LOC
** includes strategies used to help uncover themselves while their feelings of power and a stronger LOC were developing

*LOSING HERSELF** ↓ LOC – feelings shared while being in an exposed state	*VARIABLES to bridge from LH → UH* – innate abilities to facilitate movement forward	*UNCOVERING HERSELF*** LOC ↑ – strategies used when starting to feeling stronger
Exhaustion, crying, anger and rage, crazy, hopelessness, helpless, inability to cope, depressed; an inability to process, retain, or concentrate on information; isolation and guilt, scary thoughts, feeling stressed, a lack of interest in sex, and wanting to escape	Reflective and intuitive abilities, and outside resources (ie doctor, doula, MP, counsellor)	Emotional support, counselling, using aids, remembering communication skills, goals setting, time alone with SO, and pursuing previous and new self-interests

Reliability and Validity

Van Manen (1998) posits:

> The problem of phenomenological inquiry is not always that we know too little about the phenomenon we wish to investigate, but that we know too much. Or, more accurately, the problem is that our 'common sense' pre-understandings, our suppositions, assumptions, and the existing bodies of scientific knowledge, predispose us to interpret the nature of the phenomenon before we have even come to grips with the significance of the phenomenological question. (p. 46)

With this in mind, I have attempted to "bracket" my own experience with PPD, suppositions, assumptions and previous research conducted on PPD. Van Manen (1998) emphasizes that we need to make "explicit" our understandings, beliefs, biases, assumptions, presuppositions, and theories and need to "come to terms with our assumptions, not in order to forget them again, but rather to hold them deliberately at bay and even to turn this knowledge against itself, as it were, thereby exposing its shallow or concealing character" (p. 47).

To attempt to achieve this, I identified my personal stance with PPD; I obtained rich verbatim data with thick descriptions of the lived experience of becoming a mother through postpartum depression from each of the women in the study. Both typical and one atypical experience was included to add depth and possibly to make the discoveries more meaningful. In addition, the use of a journal strengthened the auditability of the study because the researcher's biases, thoughts, and ideas were set aside from the fieldnotes. Moreover, regular meetings were held with the one supervisor for feedback, guidance, and for detecting any biases. At these meetings, any understandings, beliefs,

biases, assumptions, presuppositions, and theories were shared and contemplated with this supervisor. Next, the ethical considerations that guided the researcher's conduct in this study will now be discussed.

Ethical Considerations

Ethical issues must be considered in every research study. The challenge with qualitative research is that ethical issues are more subtle and less visible (Lipson, 1991). The following discussion describes how the researcher's conduct was guided by ethical considerations in obtaining informed consent, maintaining confidentiality and anonymity of the participants, and considering the issue of risk versus harm for the participants.

Informed Consent

Women who were interested in sharing their experience of living with PPD could respond freely to the researcher after reading an information letter (see Appendix A). Interested women could contact the researcher at the number provided in the information letter. Two of the women responded on their own after reading the information letter; whereas, the other two women had the social worker, in one case, and the facilitator, in the other, call for them since they did not have an information letter at the time. The information letter provided the information necessary for the *informed consent* purpose of the study and outlined the research methodology, description of possible risks and benefits, statement that any questions would be answered, and a statement that the participant is free to withdraw from the study at anytime. For the two women who had someone else call on their behalf, the same information was provided by the researcher over the phone to the interested woman. Initially, the informed consent was given verbally over the telephone. Prior to signing the formal, written consent (see Appendix

B), each potential participant read the information letter. The reading and signing of the written consent was arranged at the first appointment. Having the information letter and written consent supported the principles of voluntary, informed consent. Moreover, the participants were not coerced to participate in the study, and were reminded that they could withdraw from the study any time without any problems.

Confidentiality and Anonymity

Confidentiality of the participants was most important to the researcher because the participants were sharing very personal information and would be vulnerable if confidentiality was not maintained. *Confidentiality* was assured by: allowing only the researcher and one thesis supervisor access to the audiotapes and transcripts, having the information shared held in strict confidence, removing all names used in the transcripts, locking up the consent forms in one place and the audiotapes and transcripts in another, and by having the audiotapes and transcripts accessible by the researcher only.

Although the participants were not anonymous to the researcher, care was taken by the researcher to maintain *anonymity* in the study as a whole. *Anonymity* was maintained by giving each participant and or family member who was mentioned in the transcripts a pseudonym, labelling all tapes with a code, and by not revealing any participant's involvement in the study. In addition, the anonymity of the physician, counsellors/therapists, support persons, who were mentioned by the participants in their experiences was maintained by removing the name from the transcripts and replacing the name with a [physician] notation instead.

Risk versus Benefit

The researcher perceived no risks to the participants who decided to join in this study. The women were pleased to have the opportunity to share their experiences, as well as how they helped themselves and what they learned as a result of their experiences with the researcher. In addition, precautions were used to maintain their confidentiality and anonymity in the study. There were two possible *benefits* for participants: the participants may have felt a sense of relief after discussing their postpartum experience with an enthusiastic listener, and all participants had the potential of feeling rewarded for contributing their personal expertise about postpartum depression in order to help prospective women who may go on to experience postpartum depression.

III. FINDINGS

Her Story Revealed

As I sit now and begin to present the findings from this study, I find myself likening it to the process of knitting a Kaffe Fassett sweater. Just as the colours and textures used in this kind of knitting pattern are unique and varied, so too are the stories shared by the women I have had the honour to meet. "Each story with it's own texture, its own feeling, its own image, arises from incidents in the everyday lives of these women. Each story reaches below the surface uncovering fragments of one person's experience which others can incorporate" (Kotre, 1984, cited in Bergum, 1989, p. 17).

While attending and witnessing their re-telling of their experiences, I found that each woman seemed to come alive as they spoke. Their voice was revealed and honoured and so in this way it feels there was much more then just a relaying of events and happenings—as what may be noticed if reading a journal or diary of the same account. Instead, the text seemed to have a life of its own. In this way, the colours and textures from each of the women's stories have been knitted together to form a new and more meaningful creation. Just as the whole is greater than the sum of its parts, the stories together connect the experiences of the four women I have met and had conversations with about PPD. Here, then, are the stories of Andrea, Rene, Teresa, and Denise.

Andrea

Andrea and Paul live in their own house in the suburbs just outside of Victoria. They have enjoyed more than a decade of marriage together in this home. Both Andrea and Paul are self-employed in the same home business. Andrea is an avid reader, and used to enjoy writing her own books before she became a mother. This is an activity she

is currently trying to pursue more seriously. Andrea has an undergraduate degree, and had thought of returning to school for a graduate degree before their daughter was born. Although Andrea has a few extended family members still living nearby, she feels an overall lack of support from them. Paul's parents and Andrea's father live in town; her mother, however, had died years ago when Andrea was just 14 years of age. Today, Andrea is 40, and the mother of a beautiful baby girl –their first, and only child, she and Paul plan to have.

Andrea had an uneventful pregnancy:

> Well the pregnancy wasn't too bad, you know, it was pretty routine. There wasn't anything went wrong, or bad, or weird. My thyroid stayed level. Actually, I didn't mind it. I didn't have morning sickness too bad. It was just mainly nausea. And, but the birth experience was the, was the big bang because I had over forty hours of bad labour.

Andrea endured a difficult labour. In the end, she managed to give birth vaginally, but then required emergency surgery to remove her placenta. She found the hospital staff to be supportive and helpful, but was surprised that her husband was not, and this she feels was what lead her to experience PPD:

> But, the nurses in, in the delivery room were pretty good. They were right there, and, and communicated well, and they had compassion. One nurse was really helpful. My husband wasn't too helpful. He just sort of left. I think it was a little bit much for him to, or he didn't know what to do.... But I think, you know, he was overwhelmed with having to look after [new baby] all those hours, you know, when I was in surgery. But I really could have used some hand-holding at that

> point in time. And I think that's, you know, one of the things that started the post-partum depression, you know?

Today, Andrea is doing much better, but continues to work through her experience of postpartum depression. Two years later, Andrea still has periods of feeling depressed.

Rene

Rene and Steven were pleasantly surprised after they became pregnant with their second child. They had tried for five years to conceive their first child, and after visiting a fertility clinic and having surgery to correct a problem, they had a baby girl. Both the pregnancy and birth experience with this first child "was a breeze":

> So [first child] was, it was a breeze, it was a breeze. I'd been sitting in a, in a Moms Meeting Moms group over at [her neighbour community] there you know, we had a speaker, and it's like hmm, I think I'm in labour, I've got to go now, bye. [Laugh.] So that was like at about ten, ten-thirty, and she was born at, at three. So.... (M: That's amazing.) Yeah, and it was like, you know, half an hour before she was born I was still playing cards with my husband. [Laugh.] And it was like, you know, a few minutes of hard labour, two pushes, and she was born, so hmm, that was, that was just amazing. So little do we know, I ended up with a, with a nice easy birth.

Shortly after the birth of their first daughter, Rene and Steven moved halfway across the country to Victoria for Steven's work. This move meant leaving all of their family and friends, with a new baby in tow, and uprooting from the only way of life that Rene had known. Two years later, Rene and Steven were living in their own home, within a family neighbourhood of Victoria, enjoying their daughter. Then, Rene had

turned 40, and was pregnant with her second child; Steven was getting less and less work and decided to leave the company that brought him to Victoria. Since moving to Victoria, Rene still had not made many friends. As for Steven, who was also her confidant and best friend, he was rarely home as he was looking for work and busy trying to make ends meet as they were on the verge of becoming bankrupt. To make matters worse, Rene's second pregnancy experience was "bad right from the beginning":

> With [second child] the pregnancy was, was bad right from the beginning because I was sick for the first seven months. I had morning sickness for seven months. And then, ... there was like problems all the way along. I went for an amnio because of my age, and when they went to do it they couldn't do it the first time because the fluid level was so low there wasn't even enough for a sample. So I had all of these specialists in and, you know, I'm laying there looking and it was just like these seven doctors all gathered around looking at the ultrasound. And so they called in a specialist, and they had me come back a week later, and the fluid level was back up again. And so they ran all these blood tests and everything on me, and they, they couldn't find anything. So the guy said we don't know what it is. It could be something that comes up down the road, or, you know, we don't know. So.... [Speaks briefly with child.] ..., and then I wasn't gaining weight. I wasn't; I'd only gained like about two pounds or something like that. So the doctors said, you know, start to eat, eat, eat, eat, eat, eat lots of stuff, so I started doing that and I think I gained about three or four pounds, and then they do that seven-month blood test or something. And then it's whoa, stop, you have gestational diabetes. So, you know, then I had to get put back on a diet, and I

> dropped a few pounds again. And so for the last few months, you know, I, I couldn't eat fattening stuff and everything, and they, I had to do ultrasounds every month. I had to come in for an ultrasound, and, and she ended up, like growing really good towards the end. She caught up and she was born at 7 lbs., 12 oz. So, but I only gained three pounds, so all the rest was what I lost.

For Rene, she feels her experience with PPD is now behind her –two and a half years later. Rene believes that her PPD was related to her hormonal level, and believing this gave her comfort as it meant that it was something that was not in her control:

> My view of it (PPD) is, and I know that some women will try and hide the fact that they had it because they think it's something mental. You know... there's something wrong with me; I just can't handle, you know, the stresses of motherhood I suppose. It's not that at all. It's like you can't control your hormones.

Teresa

Teresa and Mark were living at the University of Victoria Family Housing Complex when they had their first child –a daughter. Before their daughter was born, however, Teresa, then 28, was a graduate student at the University of Victoria. She describes how she felt at that time:

> A few years prior to [daughter] I started doing a Master's in [degree], and I was, I was mortified to speak because all these people seemed so intelligent and well worded, and I felt so insignificant in comparison and I could never even speak in class. I was paralyzed with fear.

Teresa decided to discontinue her academic program once she learned that she was pregnant. Teresa enjoyed a healthy pregnancy and felt that overall it was a positive experience—despite the mood swings:

> I had a healthy pregnancy and everything. Too hot was my only complaint. [Laugh] So, and then about, probably around five months the mood swings really kicked in, so I had like a lot of really bad mood swings... But other than that, it was, it was a very positive experience for me... So my complaint is just being too hot. No health problems or anything like that, so that was good. And I went to prenatal class with my husband and things like that, and I had a doula, which was very, very good because it was my first child. It was just nice. I don't have family here, and so it just, it was a support for me and for my husband too. Yeah, and she told us all about, you know, birth experience, and, and everything, and, and so from that I kind of made it my birth plan. And I wanted natural, no drugs, all this, but, but I think that kind of was a bit, I set myself up for disappointment by not being open to other ideas.

Teresa was the one participant who had an atypical experience compared to the other three women who were in the study. Teresa, throughout her whole perinatal period, had an abundance of support –and in particular from her husband. This was not the case with the other women. Despite the unending emotional support and help with the running of a household and caring for a new baby from her husband, Teresa experienced PPD and continues to work through it to this day – nearly three years later. Teresa recalls what a nurse had told her about PPD while in the hospital after having her baby. She was feeling depressed, and the feeling did not go away:

A few weeks of feeling a little down in the dumps or something like that. Or, or the nurse would say oh, are you a little down today, that normal, that just you're feeling a little sad, and , but it wasn't a little sad.

Denise

In just five short years, Denise and Bill had experienced many life changes. Denise immigrated to Canada from the mid-eastern United States and decided to live in Vancouver where Bill was residing. A month after they were married, they bought their first home, but needed to move into the basement of a relative's house until they could take possession of their new home. The house belonged to Bill's sister and her husband who had four young children under the age of six. About three weeks later, they moved into their new home which was in a quiet neighbourhood in Victoria. Soon afterwards, their first child [son] was born. About two years later Denise was pregnant with her second child.

Becoming Herself Through Postpartum Depression

The idea to organize my results in the following framework entitled *Becoming Herself Through Postpartum Depression* did not come to mind until quite late into the analysis. After analyzing each of the transcripts, my journal/log notes, and within the third stage of analysis, when I begin to memo and make note of other processes that may bė occurring on a much deeper level, this conceptualization occurred.

While driving I wondered why the terminology that I was using to code and code pattern the data was bothering me. I realized that it seemed biomedical, which is not too surprising since I came to counselling from a nursing background. Not to say that this is wrong, but I felt it was not enough, or rather it only touched on what was going on for

women living with PPD. Then, after more journaling and meditating on what else may be evolving, I came to the discovery that perhaps the work on identity development from the field of developmental psychology could more aptly describe what was going on for me and how I could make sense of what may be occurring on a metaphysical level.

To begin, I present the framework entitled *Becoming Herself Through Postpartum Depression*. This framework consists of five stages: *Herself for Others, Losing Herself, Uncovering Herself, Finding Herself,* and *As Herself.* It was developed in order to connect the experiences of the four women I interviewed, and also to attempt to explain why some women experience PPD for much longer periods than others.

I will present each aspect of this framework as a whole, and then more specifically with the transcripts being used to support each concept. This framework may appear linear at first, but in fact, the feelings and experiences of women living with PPD are not; this statement is based on the experiences of the four women I interviewed, my own personal experience, and the stories shared with me from friends and family. Although we may have experienced aspects of each of these stages, setbacks or surprises may have occurred that lead us to question and or regress to an earlier stage. These experiences of questioning and pondering will be exemplified later in the conclusions when each mother's experience is summarized at the end of this chapter.

Before the stages even begin, there are *Foundational Challenges* and *Triggers* that appear to be paramount in order to set a woman more at risk for experiencing PPD. In addition, there appear to be universally experienced *emotions*, by the four women I met, which seemed to act as precursors to the subsequent stages of *Becoming Herself*

Through Postpartum Depression (see Figure 2-1). Each of these concepts (foundational challenges, triggers, and emotions) will now be discussed.

Foundational Challenges

First, I will describe how these *foundational challenges* have been conceptualized. Next, I will outline each of the five foundational challenges with excerpts from the transcripts of the four women I interviewed.

The *Canadian Oxford Dictionary* (1998) defines the word *foundation* as "the solid ground or base, natural or artificial, on which a building rests" (p. 548). *Challenge* is defined as "a demanding or difficult task" (p. 235, item 2a). In this instance, the woman's life story before the postpartum period occurred represents the foundation on which her present life rests. Underlying covert memories represent the challenges she will eventually face in her life. An analogy for earlier challenges in life, which eventually will be faced for a full recovery to follow, is the building of a foundation for a home. The foundation must be solid and thoroughly laid in order to minimize the potential of having any serious problems occurring later on in the life of that building. Therefore, challenges which have not been addressed, grieved, or accepted seem to come back with the trigger of a major life change, such as with the birth of a child, before total peace, wisdom, and acceptance can occur in the woman's life.

Three of the women in this study used the following words to describe what I have identified as *foundational* challenges:

> That's really what I needed (referring to the counselling she was receiving). I didn't, you couldn't just scratch the surface of the issues that were causing this depression. (Teresa)

In Teresa's next comment, she gives us insight into what she feels those issues may be:

> It's such a big event in your life, the birth of your child, and, and it's so overwhelming. Just looking at it, all these bad memories came rushing back and so much rage and hatred of my parents, and it all came back. And I think that having the baby was the trigger that released the floodgates for me. I think that's what it was.

> There's other factors that may make it worse, that.... [Speaks briefly to child.] So yeah, there's other factors that... (M: Yeah…) Rene: ...come back and make it worse, but, you know, I don't, mind any ways, you don't have control over it, you know. I didn't wake up and say oh I think I'm going to have post-partum depression today. (Rene)

Denise metaphorically describes how this process was for her:

> The thing, this is a really deep disorder. It's not, it affects every aspect of your personality, every aspect of your life, you know. So I don't know, it just reminds me of, you know, weeding in the garden and you've got to get this dandelion that just goes way down there, and you have to get it out, right? [Laugh.] (Denise)

The concept of *foundational challenges* has been defined. Next, the five foundational challenges will be delineated. These *foundational challenges* are: childhood stories, a felt deficit in mothering (Mothering), the cascade of interventions and loss that occurred during the birth experience, experiences of loss, and a history of depressive episodes.

Childhood Stories. The *Canadian Oxford Dictionary* (1998) defines *stories* as "an account of imaginary or past events; a narrative, tale, or anecdote" (p.1432), and this is exactly how I feel the *childhood stories* can best be considered. It is not whether the stories are held as truths or not that matters here, but rather, how the woman who has bravely re-lived their memories remember them that is key. For example, children from the same family who have all experienced the same episode at the same time could all have a qualitatively different perspective on the same. A second point to note is that childhood stories appear to hold the mystery, based on the accounts of the four women I met, as to why one woman may go on to experience PPD for an extended period of time. The stories range between a remembrance of past family values to a painful, and debilitating recall of past events. Each will be considered now:

> I came from a background where you always waited for people to offer things to you. Like it was very, you were considered forward if you'd ask for what you want.... So I had a hard time asking for help, and it was really hard to admit that I needed some kind of help. (Denise)

Andrea shared the following comments which connect her childhood stories with her present day situation:

> My father, you, you can never do right by him, you know. So, yeah. He always finds fault with something. I mean, I'd joke with my friends about the jibe of the month after I'd talked to him. He's got to come up with something to insult me. It's just, he's not happy unless, you know, [laugh] ...unless he comes up with something. (M: Something's wrong with you, dad, you haven't said something and it's been five minutes). Andrea: I know, yeah, what's the matter with you?

> Yeah. Come on, insult me, get it over with. So there was that. (M: Um-hmm.) Andrea: He, he wasn't very happy about my getting pregnant, and I knew that, and so I, I, I knew he wouldn't be happy. So I didn't even tell him that I was planning on getting pregnant. I really didn't want his interference, you know. I wanted it to be a happy occasion. I didn't want the moaning. The moaning and complaining, if you will. But I mean, he's, he's warming up now. He's not a big children person. But my mother, no. It's just like in a way she's long forgotten. (M: Um-hmm. Um-hmm.) Andrea: She never came up from that, other then I don't want to be like her. I don't want to be that kind of mother, you know, that's about where it stops. But that's something that I had already worked on before I even got pregnant, before I even made the decision to have a child. (M: Really, wow.) Andrea: I just didn't, I didn't want to be, be like her, period. I didn't want to be that kind of person.

When Andrea made the comment, "It's just like in a way she's long forgotten," I wondered at the time if Andrea herself was also becoming long forgotten. Later in the transcript, Andrea makes reference to having worked through her mother's death years ago: "But that's something that I had already worked on before I even got pregnant, before I even made the decision to have a child." However, I am still left pondering whether this could be something that needs to be revisited, since the major life change of becoming a mother herself, and could possibly be the answer to why she is still presently experiencing PPD two years later.

In the next example, Teresa tells us how she has been implementing the sleeping plan suggested by her physician, however, she hints to us that her rage may be related to another, deeper issue:

> Ron was taking care of the baby and I was getting more sleep, but I wasn't a lot better. So, so then after I'd slammed the door that day I thought, I, I went to the doctor and talked about it, and, and that the sleeping wasn't really an issue I didn't think. (Teresa)

In the quote to follow, Teresa gives us a glimpse into what it was like for her to be growing up in her family, allowing us insight into the source of her anger and rage:

> All I wanted to do was get out of the town that I lived in, get far, far away from there, and not have my relatives–like I never felt like I was a true member of this family with, you know, with all my aunts and uncle, I never felt I belonged. I felt like an outcast because I was adopted, and I didn't look like them and, and act like them, and I had my own mind but it was always suppressed. (Teresa)

The next two quotes begin with Teresa stating how effective her therapy was with her psychiatrist, and why she feels it was so effective:

> And that's really what I needed. I didn't, you couldn't just scratch the surface of the issues that were causing this depression. (M: What do you think those issues were?) Teresa: My childhood, a lot of them had to do with my childhood. ....And, I mean, during my therapy, I realized I was depressed my whole life. I never felt truly happy. I remember being five and being depressed, feeling unwanted, unloved, you know. So I'm dealing with those things now. Like the post-partum depression was really, it was hard, it was hell, but I've grown as a

> person because of it. It's (therapy) made me face a lot of issues in my life, and past abuses, and I was mentally, and verbally, and emotionally abused as a child. I wasn't beaten or sexually abused, but I still think back to some of those things now and they hurt still.

While analyzing this part of Teresa's transcript, I wondered if her perception of certain childhood experiences could be the reason for why Teresa is still experiencing PPD two and a half years later. As a final note, Teresa posits her belief that childhood stories play a significant role in a woman experiencing PPD later in her life:

> But I believe that it's because of things in your past that resurface during post-partum .... So, but I think everyone that goes through it (PPD), I think it's something to do with a lot of the past coming to the surface, if they've been abused or yeah. I think that there's a, just talking, even in postpartum group a lot of us have very similar issues in our past .... Bad, bad experiences as children I think a lot of us had.

Mothering. Three of the four women commented on how they felt mothering was something they feel influenced their later development of PPD. Mothering is considered a foundational challenge separate from childhood stories because the mother-daughter bond is an unique relationship which is particularly of interest since these are women who themselves are now mothers. In addition, the women seemed to qualitatively separate mothering from childhood stories because the stories relating to the former were more specific and focussed on the mother-daughter bond, whereas, childhood stories were grouped in general as recollections from the past. The quotes to follow range from a recollection of a pattern Denise's mother had, to experiencing survival-abandonment

issues with Andrea, and then ending with a frightening memory that Teresa felt she was re-living.

> You know, so I went to see her twice, and even after the first session, we just touched on some issues that I had, and then she (counsellor) pointed out to me that, that I have like this martyr complex too, and it made sense because my mom did too. (Denise)

> I needed the mothering so that I could do the mothering. (M: Um-hmm). Andrea: Yeah, and that didn't happen. So there was a lot of survival – abandonment issues, if you will. (M: Um-hmm. And then you said, too, your mom passed away a number of years ago?). Andrea: When I was 14, yeah. (M: Did that come up at all?) Andrea: No. (M: When you had [your daughter]?). Andrea: No. I think I reconciled that a long time ago. My mother and I didn't have the greatest of relationships. (Andrea)

Teresa's story begins as a comment on how her mother expected her to behave, and then ends with a disturbing memory she has of her mother. Even to this day, she finds it hard to forgive her mother:

> So I was adopted too as a child, so I'm searching for my parents, my birth parents now. But still, I find it hard to forgive my mother for how she treated me my whole life.... Like that, it was a bad thing if I said anything my mother didn't like or if I felt sad, you know. Like that was often times I'll slap you or, you know, I'll

give you something to frown about. Like just, I wasn't allowed to feel my emotions a lot. (Teresa)

Like things that were, my mother told me that I, when I was little, probably when I was four or five, I remember hiding behind a house in the woods because my mother told me that there was something wrong with me, and if I didn't behave myself I was going to, they were going to come and take me to, to the mental hospital. And I just had these, you know, you see it on TV. People going in straight jackets against their will, and I just thought they're going to pull up and they're going to take me away because there's something wrong with me, I'm not normal. But looking back on it now, I think my mother was going through a depression, and still is I think, and didn't get the help for it and didn't have the, the resources, or the access, or anything. It still hurts, but I kind of realize things she said hurt me so much, but when you're feeling that rage and anger, things kind of pop out of your mouth too. And we, we don't have a close relationship even to this day. (Teresa)

Given how Teresa perceives her childhood stories, and the felt deficit in the *mothering* she received, I would conclude that these, as well as her birth experience, were the three key foundational challenges she holds today and may quite possibly be the reason for why she is still experiencing PPD.

Birth Experiences. The birth experience represents the cascade of interventions and loss that occurred during labour. For two of the participants, this was a particularly upsetting memory. Andrea described it as the "big bang," and the reason for why she feels she is experiencing PPD to this day:

> And, but the birth experience was the, was the big bang because I had over forty hours of bad labour. Near the end of it, (baby) hadn't turned yet, you know, so they were saying if she doesn't turn in the next little while, we're going to have to do a caesarean. So that was a bit scary, and by then I'd asked for pain medication, give me pain medication [laugh], because it was just too long, you know. (M: It's time now.) Andrea: Because they, they'd given me the (Pictocin) drip as well, you know, because my uterus had just, by that time it just couldn't keep up.

Immediately after the birth, Andrea feels a loss for the lack of bonding, and what the bonding could have been like, immediately following birth:

> But all in all, I didn't have any expectations per se of what's going to happen. I sort of did that on purpose, because I had no clue whether it would be long or short, or good or bad, or, but I did want to hold her afterwards…(M: Right.) Andrea: … you know, at least. You wait all this time, I want to see her, and I couldn't, you know, they whisked her away because the labour was so long so they had a paediatrician there. And then I retained the placenta. It wouldn't, it wouldn't come out, so they put me through surgery to help me out. So she was born at four, and so by the time I actually got to, you know, talk to her if you will, it was about eleven at night. By then I was pretty wasted.

For Andrea, three difficult aspects for her BE were recognized. Her difficult labour, missed bonding opportunity with her newborn daughter, and the third was the lack of support from her husband during this time. This third aspect will now be considered:

> My husband wasn't too helpful. He just sort of left. I think it was a little bit much for him to, or he didn't know what to do. (M: At what point? Do you remember that?) Andrea: When I came out of the anaesthetic, you know, he, because they couldn't get the bleeding to stop at that point. And then they were worried that, about giving me some more of the fluid because of my kidneys shutting down, because they had already given me so much. But the specialist wasn't too worried, but I was worried. (M: Um-hmm.) Andrea: But I think, you know, he was overwhelmed with having to look after Leah all those hours, you know, when I was in surgery. But I really could have used some hand-holding at that point in time.

Andrea ends her feelings about her birth experience, by stating she believes this was the primary reason for why she later experienced PPD:

> And I think that's, you know, one of the things that started the post-partum depression, you know? (M: Hmm.) Andrea: I think the whole birth experience, because I really needed to talk about it.

Like Andrea, I believe Teresa also needs to work through, grieve, and accept her birth experience. However, Teresa's story provides us with a different perspective on why she found her birth experience so difficult. Although both Teresa and Andrea had a cascade of intervention, for Teresa, her birth experience was the opposite of her previously arranged birth plan and her reasonable expectations. In addition, a difficult

labour and birth experience ensued despite having a wealth of resources –namely her physician, doula, back-up doula, RN (nurse-midwife), and a very supportive husband:

> Yeah. So my complaint is just being too hot. No health problems or anything like that, so that was good (speaking about her pregnancy experience). And I went to prenatal class with my husband and things like that, and I had a doula which was very, very good because it was my first child. It was just nice. I don't have family here, and so it just, it was a support for me and for my husband too. Yeah, and she told us all about, you know, birth experience, and, and everything, and, and so from that I kind of made it my birth plan. And I wanted natural, no drugs, all this, but, but I think that kind of was a bit, I set myself up for disappointment by not being open to other ideas. (Teresa)

Upon reflection, I felt that Teresa was giving us some insight as to what may have made the difference for her and how she may have reflected on her birth experience later:

> And I wanted natural, no drugs, all this, but, but I think that kind of was a bit, I set myself up for disappointment by not being open to other ideas.

Teresa continues her re-telling of her birth experience in the next example:

> Because I thought, you know, you're just going to have the baby with, you know. But my labour started on a, February I guess 10th at eleven at night, and it woke me up, and I couldn't sleep all night because of the contractions. And then around maybe five in, five in the morning my husband and, and I, I was in the bathtub trying to relieve the cramps and I talked to my doula, and my contractions were getting–he timed meticulously every contraction, and they were getting closer and closer, about three to five minutes apart.

While analyzing this part of her transcript, I felt she had provided me with a very good reason for why she experienced such a long and arduous labour. It is my contention that her birth experience could have been significantly different had she not laboured in the bath during the early part of labour, or had the sleeping pill. Unfortunately, by entering the warm water at the time she did, this likely reversed the progess of labour by reducing the efficiency of contractions, or perhaps, stopping her labour all together (Sager, 1996). In this next part of her re-telling of her labour experience, Teresa gives us another clue as to why she may have had a prolonged labour. Teresa shares with us: "I didn't feel like going to the hospital at that point, I didn't feel like I was ready":

> So my doula suggested that, you know, we start getting ready, and when we were ready to leave for the hospital to call her. And then they started getting, like they were, they were up and down, irregular, ...so, and I didn't feel like going to the hospital at that point, I didn't feel like I was ready. So it went all day, and, and, you know, around eight or nine in the morning I, I started crying because I thought I can't–how long is this going to take me because it had already been.... So I went all that day, and went walking a bit up and down the street, and, you know, ate, and drank between contractions, and, and then I was talking–my doula and my doctor were both calling me every couple of hours throughout the day. And my, I asked my doula, because she would come whenever we wanted her to because I was getting really upset and frustrated I wanted her to come down, and so she came over around three-thirty or something. And the labour went on all night. (Teresa)

In this next part of her birth experience, Teresa gives us the third reason for why she may have experienced a prolonged labour which consequently lead her to have a cascade of intervention during labour. Teresa shares with us that she was given a sleeping pill.

> Yeah. And then 11 o'clock at night, I was talking to my doctor, and she said Teresa, I want you to come in to the hospital and I want to give you something to help you sleep through the night. She said you're going to need your rest, you've been up for twenty-four hours now. So I thought okay, I, I want to sleep at this point, I just can't take this any more.

As a final note about Teresa's story, the three reasons why she may have had a prolonged labour (entering the bath early in labour, going to the hospital early and against her will, and having a sleeping pill), were likely the cause of the intervention that she received, and the reasons for why her birth experience has become a foundational challenge for her to confront and work through in order to fully recover from PPD:

> So I had that (sleeping pill), and then, and then later in the night they gave me the Nitrous Oxide. Is that what it's called? (M: Um-hmm, um-hmm.) Teresa: Does that make sense? And then I kind of drowsed between contractions. But I just found it, it didn't really relieve much pain or I was in a lot of pain. It was really, you know, it was still very, very painful. So then it continued, and at nine o'clock in the morning it was just, I was vomiting after the contraction. So about nine or something like that or a little later I discussed it with my doctor and my doula, and, and we kind of agreed that--or they kept asking me do you want an epidural, do you want an epidural, and I kept feeling that I, I was a failure somehow if I, I said yes to that after my plan,...(M: Um-hmm.) Teresa: ...and so I kept saying no,

no, because I was in so much pain and they told me they were going to put a needle in, you know, in the back and a catheter through your bladder. I, I was so irrational and thought, you know, that's going to hurt, I don't want to do that. But then finally, you know, my doctor kind of convinced me at that point. She said Teresa, and she's a proponent of natural childbirth. But I, I knew with her, like I knew if she said it was time, I had a lot of faith in her and I respected her, so I had my epidural. And so I slept from about eleven to one, and then I had to be examined, and then at maybe one-thirty, and there was, the baby was under distress and was having kind of bowel movement, so there was meconium, a lot of meconium I guess came out. And before, I'm not sure what time, but they had to break my membrane. He (another medical specialist) came up to me and he said, 'Teresa, you have to have a C-section, there's no other choice at this point because your baby's in distress and we, we have to get this baby out of you immediately'. So I was wheeled down and probably within twenty minutes/half an hour she was born. So, so I basically had every drug and every, you know, and then had to be on morphine for pain, and I was really, I found it really hard. I was really disappointed and I felt, I thought I was a failure because I didn't have my baby the way that I should have or I felt I should have. Because prenatal, and everything is natural, natural, and what I was reading. (Teresa)

To summarize, Teresa ended up having a cascade of intervention and throughout this she was experiencing the loss of not having a natural childbirth as was requested in her birth plan. Instead, as Teresa so aptly concluded, " I basically had every drug (Nitrous Oxide, sedation, Morphine, and query Gravol for her vomiting) and every (intervention)"(an

epidural and her baby under distress which lead to emergency surgery), and this is what made the difference.

Experiences of Loss. The experiences of loss are those things that are part of a mother's 'old self' or previous life before this baby came. For example, not being able to enjoy the things that were taken for granted in her old life:

> But just the things that we take for granted in life. Sitting down with a cup of tea, I couldn't do. (Teresa)

For Andrea, it was being able to sit down and enjoy reading a book:

> I asked her to come and help me, you know, so it was a disappointment that she didn't. You know, I really needed the help. I needed to be the one sitting down with a book for a while.

Much later on in the transcript, Andrea tells us about how she still grieves for her old life and who she used to be –a career-minded individual:

> And you really want to have an intellectual conversation in the very least, you know, and you'd would like to read something that has more than five pages, you know, you're still a person with a brain. You're still a career-minded individual. .... Well I think that you do grieve for your old life. You know, being able to sleep in, you know, and read all afternoon if you so choose on your day off, you know, and just oh, well let's just go away for the weekend and you just pack your bags and go. And the thousand and one things of how your life changes.

Finally, Andrea has some interesting comments about why she feels it is even harder for older moms. In addition, you can 'hear' the loss she feels for not being able to have a

regular maternity leave, whereby, she could just enjoy her new baby –without the worry of her usual work commitments since she is self-employed:

> And I think for older moms it's even worse because they, you know, like you don't have five-ten years to take out to raise your children if you're 40. You know, like not that your life ends by no means at 50, but career wise it becomes a lot harder. You know, your energy level isn't quite there yet, you are getting older, and people start looking at you. Oh, you're fifty. Well, you know, there, there is a stigma, you know, as much as we don't, we don't want to admit that there's this fear, like oh God, if I take five years out, there ain't going to be nothing after that. You know, and there are for the moms too, that are forced to work. Like myself, I wish I could have just taken six months mat leave like everybody else, or a year as it is now to just take care of Leah and not have to worry about, you know, bookkeeping, accounting, and, you know, blah-blah. (M: Um-hmm.) Andrea: You know, I could just lie down and sleep when she sleeps and play with her when she's up, you know…(M: Um-hmm.) Andrea: ...and not have to worry about these other things. (M: Um-hmm.) Andrea: And yeah, the moms that are, you know, forced to go back to work in three months or whatever, because, I mean, that's not, not much of a problem in this country but, you know, at six months, poof, back to work, you know, and somebody else raises your kid, and you really don't want to do that. (Andrea)

Denise also grieved for her old life when she was working as a teacher:

> I had a hard time, even just moving here. So I couldn't work, and I, you know, until my landed immigrant status came through.

Not only did Teresa grieve for her old life, but also the childhood she never had:

> Feelings of resentment and loss that I didn't have that childhood. I look at her (her baby) and think how I was treated and, and being so scared that I was going to treat her like that.

To conclude the meaning of this fourth foundational challenge, experiences of loss were about the ways of being in the her old life that feel a lifetime away from the present reality of her new life. Next, the fifth and final foundational challenge, a history of depressive episodes, will now be discussed.

History of Depressive Episodes. In this study, a history of depressive episodes does not refer to the number of clinical diagnoses of depression a woman has experienced, but rather it refers to the number of times, based on her own recollection, when she felt depressed for a period in her life. Three of the four women (Denise, Andrea, and Teresa) had a history of depressive episodes. For Denise, she remembers feeling depressed soon after the birth of her first child:

> I think I had a slight depression after [son], but I had, you know, moved to a new—we got married in '92, and [son] was born in '96, and I, I had a hard time even just moving here [to Canada from the U.S.].

For Andrea, depression is depression no matter how you label it:

> (M: Andrea, you were saying that before in the past you've experienced depression?) Andrea: Um-hmm. (M: Would you say –what is similar or different about depression and post-partum depression, if we want to use those terms? Like what you've experienced most recently, as opposed to what you've experienced in

the past. Andrea: It's very similar. I think depression is depression no matter how you label it.

Although it is not clear as to when Andrea felt depressed, what is important here, I believe, is to note that there was a period in her life when she felt depressed. As for Teresa, we heard earlier, in childhood stories, how she felt depressed as a child. In her own words, she states:

> In therapy with Dr. (her psychiatrist), I told her one day... I said I've had depression my whole life. I've never been truly happy.

To summarize, there are five foundation challenges (childhood stories, mothering, birth experience, experiences of loss, and history of depressive episodes) that seem to represent underlying issues that women need to work through, grieve, or accept before they can feel at peace with where they are presently in their life journey.

Triggers

I have noted key *triggers* that may have contributed to propelling each of the four women I interviewed into experiencing the five stages of *Becoming Herself Through Postpartum Depression.* These *triggers* have been grouped into one of four categories: a *colicky/clingy baby*, *grave financial concerns*, *major life changes*, and having an *older child* who has also experienced a major life change –from being the baby to becoming the oldest child. To begin, I will explain how *triggers* have been defined here and how these are considered different from the stressors that are within the *Losing Herself* stage. Following this, I will support each category with transcriptions from the four women I have interviewed for this study.

The *Canadian Oxford Dictionary* (1998) defines *trigger* as "an event or occurrence etc. that sets off a reaction or chain reaction… set (an action or process) in motion; initiate, precipitate" (p. 1550, item 2). In this case, the personal stressors, categorized in one of the four groupings above (colicky/clingy baby, grave financial concerns, major life changes, having an older child), may have been what initiates the chain reaction, along with the aforementioned *foundational challenges*, to set off an *emotional* reaction. Before a woman enters into one of the stages of *Becoming Herself Through Postpartum Depression*, she will experience one of the five *emotional precursors* (fear/guilt, hopelessness, anger, acceptance, peace, and wisdom) depending on which stage of her recovery she is in.

Triggers are defined as stressors that are considered troublesome, but are not necessarily considered stressors by all postpartum women, and which cause a woman to experiences the stages of *Becoming Herself Through Postpartum Depression.*. For example, only two of the women (Rene and Denise) had older children. Teresa tells us that having a new baby (*major life change*) was the "trigger that released the floodgates" for her. Finally, what was considered a major stressor (a Christmas Craft Show) for one woman (Andrea) was not a stressor for the other three women. Therefore, triggers are considered stressors that are unique to the woman involved, whereas, stressors in the *Losing Herself* stage are those things that are more universally experienced as suggested in the research literature.

Colicky/Clingy Baby. The theme of a *colicky/clingy baby* evolved during analysis and appeared to be one of the more important triggers that predisposed a mother to feeling depressed postpartum. In other words, it was "the icing on the cake" which

initiated two of the women in this study to have PPD. The *colicky/clingy baby* in this study was a baby who was unable to be put down comfortably. The mother of the *colicky/clingy baby* perceives that she "couldn't put her down":

> I couldn't put her down. She was crying the whole time, and every time I would put her down she would cry because she had colic as well. So the only place she was actually happy is if I held her, and well, you know, with a new baby you can't really make a sandwich and hold a new baby at the same time. You know, I mean, now I can sling her on my hip and be done with it, but, you know, so there was that. It was like I really, really tried hard to survive. (Andrea).

As I read this part of Andrea's transcript, I was recalling how uncomfortable I was with hearing my firstborn cry, and how insecure I felt with the care of this new being. Was I doing it right? What am I doing wrong? How can I make her comfortable? What else could I be doing for her? I find it interesting that women who have more children, and who later develop PPD for the first time, may not have had this experience of questioning. For instance, after the first baby and with subsequent children, I believe one becomes a little more comfortable and less concerned about running to meet the demands of children. For this reason, I have thought of this as being a trigger for two of the women in the study (Andrea and Rene), and not as being a universal trigger – like the stressors to be noted in the *Losing Herself* stage, since some women may never have the experience of having a *colicky/clingy baby*, yet, they still experience PPD.

For Rene, the experience of having a *colicky/clingy baby* would last for several months:

> She started with, like really early, so she was a, one of those, you know, crying all the time babies who always was colicky.... She was probably only about six or

> seven days old and she started with the colic already.... You know, and then she was still really colicky and.... (M: How long did the colic last?) Rene: Until she was about seven or eight months.... She went through real like separation anxiety and a stranger anxiety. (M: Um-hmm). Rene: She never wanted anybody but me to hold her. Not even her dad.

While analyzing Rene's story, I wondered if her *colicky/clingy baby* was perceiving and then commiserating with her mother's stress and worry, given the other triggers *(grave financial concerns* and *having an older child)* she was also living with at the time. Might the duration of having a *colicky/clingy baby* been reduced had the other trigger, a serious financial burden, not been an issue? For instance, Rene and Steven were in bankruptcy at the time of their second child's birth. This second factor, financial concerns, will now be considered.

Grave Financial Concerns. Although financial concerns can tend to be a relative term depending on who one is talking to and the context in which the conversation is taking place, in this study, *grave financial concerns* referred to those women who were on the verge of becoming bankrupt or who were in bankruptcy at the time of the baby's birth. In addition, *grave financial concerns* referred to a lack of resources for support (housecleaning, baby sitting, take-out meals, baby supplies and groceries, midwife, doula, counselling), if support was not available through other means such as with the help from family and friends. Unfortunately, this was the reality for both Andrea and Rene.

> But eventually, you know, paperwork from the government arrives and you have to, and I also had like a Christmas craft fair that I had already committed to that I had to do in November, which was about six weeks after she was born. So I had

to prepare for that. Not that I really wanted to but you know, you make commitments. And if you don't catch the Christmas season in what we do, you are kind of hooped for the year. So I didn't have much choice. But yeah, I just had to go back to work, and, you know, there was the house to take care of, and [new baby] to take care of, and there was just too much.... There was no support in my circle, and that was hard, you know. That really contributed to the depression, you know. (Andrea)

No I never had any kind of help, and not really any, I had no support system because I don't have any family here. So, you know, I had no brothers, or sisters, or parents, or anything around to help, and really I still didn't really have, you know, any friends ... I didn't make a circle of friends, you know, people that you meet through work or whatever.... You know, I think a big part of what really contributed to the depression other than just the hormonal thing was my lack of support around here (Rene)

And, you know, he's the, he's the, the optimist. It's like oh don't worry, we'll find a way to pay for it, and ... (M: Yeah.) Rene: So, you know, I lay awake at night sometimes thinking about it, so, you know, that stresses me out. You know, because we've, we've had some really, really tough times because the company my husband worked for, there was hardly any work, so if he didn't work he didn't make any money. So it, it will be two years in September that he had finally said, you know, I can't do this anymore. He quit his job and started his own business. So it hasn't, you know, it's improved a little bit, but still it's still

> that struggle, and, and I'm the worrier of the family. I worry about everything. You know, I worry about, you know, how are we going to pay this, and we're so in debt here, and we're so broke, and blah-blah-blah… (Rene)

As Andrea and Rene tell us about what it means to them to feel *grave financial concerns*, I notice that when they refer to not having help from their family and friends it is more about not having help with the tasks of living day to day with a new baby. Later this lack of connection with family and friends changes from a need for support and escalates into a feeling of *isolation* –which will be discussed in the *Losing Herself* stage of the framework.

Major Life Changes. Once again, *major life change* like *grave financial concerns* is a relative term and is a subjective experience. What is considered a *major life change* for one woman, is not necessarily perceived as a troublesome *major life change* for another. In this study, *major life change* were defined as those things that the mother believed had significantly affected her life, and in turn, became the catalyst which triggered her into becoming depressed postpartum.

Inarguably, a new baby represents a *major life change* for new mothers. However, for Teresa, it was not just the aspect of becoming a new mother, but rather, the new baby triggered memories from her past that she believed was the primary reason for her development of PPD:

> It's such a big event in your life, the birth of your child and it's so overwhelming. Just looking at it, all these bad memories came rushing back and so much rage and hated of my parents, and it all came back. And I think that having the baby

was the trigger that released the floodgates for me. I think that's what it was. (Teresa)

As it turns out, Andrea felt that the new baby represented a *major life change* for her as well:

So there was just the whole being a new mom to deal with, and having to talk about what happened. (Andrea)

I wondered if Andrea was being triggered by memories from the past as in Teresa's situation. Could this be the reason why both Teresa and Andrea have experienced PPD for more than 2 years?

Just as with the aforementioned *triggers, major life change* are those triggers that are unique, and are not necessarily the experiences of postpartum women in general. For example, Teresa and Andrea's depression may have been triggered by experiences from their past, but not all women who have a new baby will encounter this experience. In the next example, Denise describes some of the transitions that were going on in her life after recently immigrating to Canada:

[Her baby] was born in August and we moved from, he was born in Vancouver in August. And we moved over to Victoria in September, and then –oh no, October because we lived in [sister-in-law's] basement for awhile. [Laugh]. Yeah, in October for a week or something. Yeah, and my parents came to see the house and to see [new baby] ... because they had never seen [baby] yet, and I remember after they left that I just felt awful. (Denise)

I have often believed that positive major changes, which are planned or which finally occur after great hope and anticipation—such as buying your first home or having a new baby, also serve as triggers to later developing PPD. Finally, the last trigger to be discussed is having an older child.

Older Sibling. Mothers who already have a young child at home face additional challenges or opportunities depending on how the now 'older sibling' feels about the new circumstances. Despite whether this child considers this a positive or negative experience, the child inarguably will be experiencing a major life change –from being the baby to becoming the oldest child. In addition, this transition for the mother could also be a trigger for becoming depressed postpartum.

In this study, two of the mothers felt that their depression was triggered by the older sibling. For Denise, it was an old memory of her life and what her role used to be, and a reminder of how trapped she feels now in her present life. In this situation, Denise vented all her anger and resentment onto her older child –who at the time was just three:

> [New Baby] was –and I never, you know, in the literature and everything it says that sometimes people hate the baby, or they can't take care of the baby, or they blame the, you know, like your anger gets focused on this, the negative energy gets focused on the baby, but I never felt that about her, but I did direct a lot of it at [older child] I think. You know, like to me she was a baby, and she needed care so I didn't mind that she was crying and stuff like that, but [older child] was demanding through it all, but he was just being three, right? (M: Yeah.) Denise: And I think I directed a lot of hostility toward him. I'd just say things to him and I just wanted him to go away. You know, I barely had the energy to dress myself

> and feed myself, and I, I just could not, I, I was really bad at trying to meet his needs.... I'd be mean to him and I resented him.

In Rene's case, the *older child* in combination with the other two triggers, a *colicky/clingy baby* and *grave financial concerns*, set off Rene to vent her feelings out at her eldest daughter –who at the time was just two:

> I did a lot of yelling at my, at [older child]. You know, there was a lot of screaming and yelling at her. (Rene)

To summarize, the *foundational challenges* (childhood stories, experiences of loss, history of depressive episodes, mothering, birth experience) together with the *triggers* (colicky/clingy baby, grave financial concerns, major life changes, having an older child) predispose a mother, who has recently given birth, to become depressed postpartum. With this in mind, there appear to be key *emotional precursors* (Fear/Guilt, Hopelessness, Anger, Acceptance, Peace/Wisdom) that naturally seem to evolve as she lives through her postpartum depression experience. Having said this, these emotions are not necessarily linear, and I believe may fluctuate depending on which stage, of *Becoming Herself Through Postpartum Depression,* she is presenting living through. After conducting this study, reflecting on my own personal experience, and the experiences of friends and family who have shared with me their stories, the process of living through depression at this time seems more about the woman's identity development and what she eventually would like that to look like or become as she matures.

The Framework

The framework, *Becoming Herself Through Postpartum Depression*, has been conceptualized into five stages: *Herself for Others, Losing Herself, Uncovering Herself, Finding Herself,* and *As Herself.* Before entering these stages, there appears to be *emotional precursors* which develop and propel the mother into entering, and in some cases returning, to a particular stage. Within each of the stages, there are five elements that develop and change as she moves through her PPD into recovery. These elements are: the *language* she uses, the tone of her *voice,* her *perception,* her *locus of control* (*LOC*), and her *relationship with her significant other* (*RSO*). To begin, the stages will be introduced consecutively and defined with descriptions of the emotional precursor associated with the stage. Next, descriptions of what it is like to be living in that stage of PPD will be given to help define the stage. Following this, the five elements (*Language, Voice, Perception, Locus of Control, Relationship with Significant Other*) will be highlighted and defined in a continuum to demonstrate how the mother's conceptualization of herself and her identity expand and become all encompassing of who she was, is and will be at the end of her journey with PPD.

Herself for Others

The first stage, *Herself for Others*, was surrounded with feelings of *fear* and or *guilt* for the women in this study. The mother may be having feelings of fear because she may not want to speak up and voice her true feelings about how she is really feeling, and what she would rather be doing at this point in her life. The mother may be feeling guilty because her true feelings about motherhood may not be what she initially expected or what her family or society expects of her at this time. For example, prior to the birth, the

mother may have been working and enjoying her outside employment. However, upon becoming a mother she learns that her decision to return to work has changed. She may feel fearful to tell her significant other her true feelings of not wanting to return to work, and instead stay home to care for her baby, after her insurance runs out. This in turn may lead to feelings of guilt because this mother's outside income may have contributed significantly to their standard of living. On the other hand, the mother may discover she wants to return to her former outside employment, and may feel fearful about revealing her true inner feelings. She may experience feelings of guilt because she is not living up to perhaps her own ideals, or her family's, or society's expectations of being the 'at home mom.' I believe that when this level of honesty with herself and others does not occur, whether it be a conscious decision or not, she is in a place whereby she is living a role for others, and this denial will eventually work itself out when the inner resources are available and can be used.

Here is how the women in this study described their feelings of fear and in some cases guilt:

> I think that I had a lot stored up in me that I didn't tell anyone because I was afraid that they would think I was crazier. [Laugh] You know, but I had all these feelings and I, and I felt guilty for having them. I always thought I wanted to be the mom at home, and it just wasn't working, and I think that I really struggled with that, you know.... I don't know why I was feeling guilty. I guess because I, I couldn't, I was supposed to be this mom. I was supposed to be the adult in charge of my house and my children, and I couldn't do it (Denise).

For Teresa, her feelings of fear and guilt developed while attending a 'Baby Talk' group in the community. Instead of revealing to someone, perhaps a facilitator of the group, her true feelings and discoveries, she felt pressured to assume a "fake smile" and join into the "brag session":

> And, and being afraid. If I go and say that there's something wrong with me and I'm not happy all the time, because I'd go to Baby Talk, and all the mothers were sitting there smiling, happy, and you'd have a fake smile on. And we'd go around that group and everybody would kind of tell what was happening with their baby so it was kind of like a brag session. Oh, my baby slept six hours last night or, you know, things like that, which was nice, but I remember thinking I'm a bad person. I'm a bad person for yelling all the time and having these bad feelings when my baby won't stop crying.... I was overwhelmed by guilt a lot of times for those feelings.... I was just pretending that everything was okay. (Teresa)

Like Teresa, Andrea also did not feel like she could share her true inner feelings:

> The reality still hits when you come home, and where, where are you left with that? And yeah, like, you know, a place where mothers can actually go and say well, you know, no, this isn't right ... like things that you're not supposed to say, you know, because you're afraid. (Andrea)

The feelings of fear and guilt associated with this stage, *Herself for Others*, lead the woman to continue leading the life of the *Model Wife and Mother.* In other words, she is the "Martha Stewart" of motherhood:

> I was trying to handle everything myself. (Rene).

Or, as Denise considers her role at this time:

> And so I think that's how you're supposed to be a mom, is by taking care of everyone else and putting yourself last (Denise).

Andrea defines these feelings at this stage beautifully in the following account:

> There's like this challenge to a role and this challenge to existing structure that is not going over well.... And ...you know, it's like you have to–if you take time out for yourself ... if you say that I'm more than just a mom, you know, then you are in a way neglecting or denying your motherhood. You're being bad and selfish, and there's all these things keep cropping up. They say you're supposed to take care of yourself, but then they say the needs of the child come first. And sometimes well they conflict, you know, it's, it's like obviously the needs of the child come first, but then other people have to help you to, you know, take care of your needs. And somehow that doesn't happen, and I see it not happening for a lot of mothers. You know, it's like okay, you know, the mother has to take care of her parents, the mother has to take care of the children, the mother has to take care of her husband, the house, a lot of work, it just goes on and on. And well, who takes care of the mother? (Andrea)
>
> Women are not supposed to deal with anger, you know, we're supposed to be nice because that's our job to be nice, and sweet, and, you know, giving, and that sort of thing.... And expressing anger, standing up and saying, you know, look, I do not like this anymore, you know, it's like get it together people, that's something that's frowned upon as well. You start, you are looked at as unstable.

.... You think oh, they'll get it together eventually, and I'll just be a nice girl and they'll love me. (Andrea)

At this time, when a mother is living her life for others, she is in the process of spiraling down until she 'hits bottom.' As will be shown, her language becomes emotionless, she denies her inner voice, her perception of her world is narrowed and is not necessarily shared by others, her inner *locus of control* is buried, and there is avoidance of issues between herself and her significant other. It is at this point that she is losing herself.

Losing Herself

In the second stage, LH, the feelings of fear and or guilt changed into feelings of *hopelessness* for the women in this study. It is at this time that the mother has "hit her bottom" and will not begin to slowly spiral out of this place until she finds the energy from within to do so. This is a time when mothers begin to forget what they used to enjoy and if they remember they forget how to do it. If they tried to do it, it felt awkward or they felt out of practice. This is not surprising when one considers how physically exhausted a postpartum mother feels as well as the time constraints she feels. For example, what used to take just a couple of minutes to do, like getting dressed and ready to go out, now takes half a day with a new little one to consider. This is also a time when the woman's inner voice is 'quieted' and she denies what she needs, therefore, leaving herself behind. Denise describes this stage well:

> The worst part was the hopelessness. And my sister-in-law in Ohio, had postpartum depression, and I, I just thought, I didn't understand at all. I thought

> she just needed, you know, a kick in the butt, and get going, and, you know, [laugh] and now I understand what it's like. But the hopelessness, to live without hope is like a wall came down, you know… I had this feeling that I could not accept a change. Like I was just stuck, and, and that was it. There was no way I could help myself out of the mess. I saw no, I saw no hope, and that was the scariest part was the loss of hope.

In the *Losing Herself* stage, the mother in this study felt sad, lost, and hopeless. It is a time when she is simply just existing and living an empty life. The days and the weeks become a blur, and she is left drifting, and may feel like she does not exist anymore:

> I became almost nothing. You know, I, I became a mother but that meant I didn't exist anymore…. Your breasts are somebody else's, you know, and your hands belong to, you know, the laundry, and you can't, there's all these parts of you that keep getting taken away. (Andrea)

For Teresa, the 'baby blues' never went away:

> I really don't know what the baby blues are like because I think I just started right away, … but it didn't go away. I kept saying to [husband], I'm still crying, what, what's wrong with me? I was upset all the time, filled with rage a lot of times, just so angry, and I was always yelling at my husband.

All of the mothers felt exhausted, found themselves crying, and continuously felt depressed:

I barely had the energy to dress myself and feed myself (Denise).

It was a combination of the lack of sleep and just being really depressed, and really stressed out, and I did a lot of yelling at my, at [oldest child]. (Rene)

The language of the participants, in the *Losing Herself* stage, changes from being emotionless to being more negative. Her voice sounds empty, and her perception of her life is also negative and hopeless in view. Her *locus of control* moves from being buried to exposed –her inner self left feeling vulnerable and open to the element. For some they may not even wish to live any longer as they just want the pain to end. The universally experienced feelings, often noted in the literature for women living with PPD, are recognized here in the *Losing Herself* stage because of how diminished her sense of control is at this time. Finally, the *relationship with significant other* is challenged. The significant other may wonder when she is going to "snap out of it" and "where did the woman I loved go?" The significant other may feel like he is "in the doghouse" since he is someone who she can vent at while her inner self is trying to come through this horrific time. At this point, the anger and rage she feels will eventually propel her into the next and most exciting stage as she begins to utilize this energy to uncover herself.

Uncovering Herself (UH)

The third, and perhaps most exciting stage is the *Uncovering Herself* stage. The women in this study felt a lot of anger and negative energy. I believe that this anger is imperative since it will provide the energy and hope for what is needed to uncover herself. This is recognized as her *locus of control* becomes more positive and she

considers her effect on others. This recognition then motivates her to adopt strategies to help pull herself out of her depression so that she may uncover herself. All the negative energy that has built up while she has felt her worst begins to propel forward as she begins to recall pieces of herself and add others that she has discovered that she would like to incorporate into her renewed self identity. She is beginning to feel more hope and at the same time *anger* for new realizations she has uncovered, as well as, anger for what she has missed while feeling deeply depressed. It was at this time when I remember saying to my husband, "I want myself back!" In the following example, you can hear the anger in Andrea's voice:

> I don't want to have to make lists for people and tell them okay, you've got to do this, you know, you have to give me more respect, you know, come over and help me. Hello, I'm really tired here! It's ... like what is wrong with you people? It seems like common sense, so what is wrong with them? I mean, my mind can make up all sorts of reasons, you know, but what is the reason? And I don't have the patience, you know. I just like want to smack them up the side of the head and say what is the matter with you! .... Like how much do they expect from me? I'm doing more than is humanly possible.... I keep saying these words, I keep saying this is what I need, and it's like it bounces off. They're not hearing it. It's almost like they don't want to hear it! (Andrea)

Teresa was frightened by her anger, but this is what eventually gave her the push she needed to call for help:

As soon as my husband would get in the door I'd give him the baby. Because I'd just be very angry when she was crying.... I'd feel like throwing her on to the floor. (Teresa)

Once the anger is being used constructively to help uncover herself, the mother becomes very protective of herself. I have coined this as becoming a 'Mother Grizzly' (for herself) so that nothing will interfere or hinder this process. She begins to feel powerful. Denise poignantly describes this transitional period between the *Losing Herself* stage and the *Uncovering Herself* stage:

I felt like this life preserver out in the ocean, and all of these people were just grabbing me and pulling me under, and I, and I really felt like a wild animal backed in the corner too. I felt like it was a real me, or them kind of thing. Like there's no way it could be us because I couldn't help them, so it would have to be me, you know, and so I was very, I don't know, but I felt like a cat that's in a fight.... I felt like there were people sort of pawing at me.... And that's why I remember having this feeling that I was this life preserver in the ocean and they were just pulling me down, you know, and I have to get out. You know an they talk about wanting to save someone who's drowning like that, that you don't go into the water unless it's the last resort because they'll pull you under too. And that's how I felt. I just felt like they were going to pull me under, and I was going to die if I didn't detach myself from them sort of thing because I just couldn't take care of myself al all. (Denise)

It is at this point that she begins to have some good days with the bad days. In other words, the clouds are beginning to lift away:

> I'd have a, an okay day and I'd kind of put it –oh, it wasn't that bad. I'm okay (Teresa)

> I didn't want to continue going through it… and I wanted to do something to help. So that why, you know, I, I agreed to go see [counsellor] (Rene).

Denise metaphorically recalls how this time was for her:

> Like it took awhile; it wasn't like the difference between night and day, but it was sort of like … if you're at the lake in the morning and there's a fog and then it starts to burn off.

As the fog begins to lift, the language she uses and her tone of voice both begin to have energy – you can hear the anger that is working it's way through. Her self-perception becomes more positive, encouraging, and forgiving. Her *locus of control,* which recently felt exposed, is now more like a 'lean-to' shelter. Her *relationship with her significant other* is becoming more like a partnership –"I'm okay, you're okay." She is on her way to 'finding herself'.

Finding Herself

The fourth, and for some of the women in this study, final, stage of *Becoming Herself Through Postpartum Depression* is the *Finding Herself* stage. It is at this point that the mother begins to feel the cloud lifting. A time where there are more good days than bad and she feels full of hope. This is also a time where she feels she has moved through her depression, and sorted through any earlier issues which were blocking her growth, and feels she knows herself well enough to recognize when she is slipping and

may need to ask for help. At this point, she feels stronger and feels thankful for the experience of living with PPD since it has made her stronger.

The energy that helped propel the mother to this stage is beginning to settle as she reaches a place of *acceptance*; she is more calm and reflective. After Denise reflected on how strained her relationship with her oldest child was after the new baby came, she recalls an appointment she had with her counsellor and a comment this counsellor made which helped her moved forward to a place of acceptance:

> He's young enough that if you change now he'll be okay. And so that set it up for me. And the guilt from having ruined my child just fell away. (Denise)

> You reach a point that you kind of are ready to move on. (Teresa)

Supportive comments also helped Andrea move towards a place of acceptance:

> You know, just being a person, just being loved... Even somebody just saying hey, you're being a good mom, because, I mean, there's a million things that you have to learn and a million mistakes that you make.... Five months, maybe six months afterwards (she began to feel okay)... but yeah.... You really begin to understand what is important. (Andrea)

For Denise, she knew she was at a better place because she started to feel more like herself:

> That's what it was like –you're at the lake in the morning and there's a fog and then it starts to burn off, and I could, I felt more like myself. And I remember on

> day, like I, I was so happy, and then I just, I was feeling all this joy, you know, and then when I thought about it I hadn't felt it for a long time, like a year and a half, and I though oh, my God. And I started to cry [laugh] because I hadn't been happy in so long. (Denise)

With respect to the five elements, the mother's language, in this study, was more positive and reflective in nature with a calm tone of voice. Her self-perception and worldview is more positive, encouraging, and more full of forgiveness. Her internal *locus of control* is stronger, and is more of a 'shelter' for her inner voice. As a couple, her *relationship with her significant other* is much stronger and more resilient; they are more of a couple: "We're okay."

Rene assists us by giving us insights into the difference between the *Finding Herself* stage and the fifth and final *As Herself* stage:

> In hindsight, ... I made it through, it wasn't so bad, but it was like still, I don't think I'd want to do it again. It was like thank goodness we always said we'd just have two kids. [Laugh]. So I didn't have to worry about my husband going oh, let's have another one. It's like no. Not unless you want to visit me and the kid in the looney bin.... It's like just, just going through all of that again, it's like no. I couldn't do that again. (M: Um-hmm). Rene: Forget it.

The difference between the *Finding Herself* stage and the *As Herself* stage is that in the *As Herself* stage, the mother no longer has any fear about experiencing PPD again. She has learned about herself and what it is she needs and how she would access the resources she needed if her own inner resources became depleted. She may feel gratitude for her

experience, and the opportunity to live more fully and in a more enriching way as a result of her experience.

As Herself

The fifth and final stage, *As Herself*, may or may not be reached by a mother in her journey, however, it was reached by one of the mothers, Denise, in this study. This feels different from the *Finding Herself* stage since the mother actually voices that she feels no fear should this experience of depression come again. The emotional precursors at this point are *peace* and *wisdom.* Other aspects of this stage would be a feeling of acceptance and love for who she is and where she is at that time in her life. A feeling of forgiveness for the unforgivable things that may have occurred or been absent while growing up and then later in life. I also see this as a time when wisdom emanates from her very being and she transcends her experience of mothering into something that is broader to encompass the mothering she may require for herself from time to time. Specifically, a woman who does not feel she must please everyone, be loved by everyone, and does not find herself denying her thoughts, feelings, or behaviours for what they truly and honestly are – living with a sense of congruency between her inner and outer voice. She is reflective and honouring of her experience. This is a stage where she has truly gone full circle and returned to herself as a stronger, and purely authentic version of herself, as herself.

The language she uses is reflective and wise. There is now laughter in her voice to accompany the calm she gained while in the *Finding Herself* stage. Her self-perception is one of forgiveness, acceptance, and is open to critical reflection from others. She is able to receive and accept critical feedback; this is something that is unique compared to the

other five stages. She is "at home" with her *locus of control* –a place she will return to, to feel rejuvenated and also when guidance is needed to assist others. Her *relationship with her significant other* could be described as interdependent and stronger than ever: "us."

For the purposes of clarity, this framework, *Becoming Herself Through Postpartum Depression,* has been presented in a linear fashion. However, having said this, I do believe that it is possible to go between the stages depending on what circumstances and life experiences may come up in a mother's life. For instance, something as drastic as the world events that occurred on September 11, 2001 in New York, or as subtle as a trigger from present day which returns her back to an earlier and very painful time, may be all that is needed for a setback to occur. The difference may be though that the mother who has reached this final stage of authenticity and clarity would likely have a setback for a shorter period of time and that these periods would come relatively infrequently compared to a mother who has reached level four and feels she has 'found herself' and recovered from her PPD experience.

The Elements

The *Canadian Oxford Dictionary* (1998) defines the word *element* as "a component part or group; a contributing factor…" (p. 452). In this study, there are five elements to each of the five stages and these are: *language, voice, perception, locus of control (LOC),* and *relationship with significant other (RSO).* These elements have been grouped together in order to demonstrate how the mother's stance (position) with respect to each element expands. For instance, in the beginning, the mother's perception, in this study, is narrow in the *Herself for Others* stage, and becomes broad and inclusive in the

As Herself stage (see Figure 2-2). Each element will now be delineated with excerpts from the transcripts of the four mothers who were interviewed.

Language and Voice

Lev Vygotsky, one of the grandfathers of developmental psychology (the other being Jean Piaget) posits speech and language develop in social interaction. At first it is internalized by the language of the child's caregivers and then develops into an inner language and voice as the child matures (Goldberger, Tarule, Clinchy, & Belenky, 1996). I felt drawn by Vygotsky's analysis of the development of language and voice as this process of the mother finding herself reminds me of the development of language and voice that Vygotsky posits. In the following transcripts from Andrea, and then Teresa, notice the tone of the language that is used in the *Herself for Others* stage. In the first example, you can hear in Teresa's voice how she is passing over her inner power to her specialists –her authority figure. In addition, the language is more analytical and less filled with emotion:

> Yeah, she [obstetrician] does breastfeeding studies, and she's going to research breastfeeding for six months... but I, I knew with her like I knew if she said it was time, I had a lot of faith in her and I respected her, so I had my epidural.... And before, I'm not sure what time, but they had to break my membrane.... So I felt that's what you should have; and I was very disappointed in myself. I felt like a failure, and it was really hard. Even though I had this beautiful baby and there was no other way, I, I was saying I must have done something wrong. It must have been my fault that I wasn't dilating and that she wasn't coming out. (Teresa)

In the second example, Andrea is, at first, referring to her labour and later to the financial responsibility she feels once she has returned home:

> But I think, you know, he was overwhelmed with having to look after Leah all those hours, you know, when I was in surgery. But I really could have used some hand-holding at that point in time (p. 2) ….
>
> (M: Now with your home business, did you feel pressured to work at that?
>
> Andrea: There's nobody else that takes care of it. I had to do it.

Once again, Andrea's language is emotionless and more analytical in nature:

> I really could have used some hand-holding at that point in time.

Also, her language is closing off possibilities for her, "There's nobody else…. I had to do it." Andrea was denying her inner voice, by not telling her husband what she needed (hand-holding), which intuitively knew what was needed at that time.

As the mother begins to feel more depressed, her language becomes more negative and her voice becomes empty as she loses herself more deeply in the *Losing Herself* stage:

> In fact, like nobody asked me how I was. And about two months later a friend of mine actually asked how I am, and I didn't have an answer. You know, when somebody asks you the same question all the time, you have that answer. You know what to say. And I just, I didn't know how to answer her. (Andrea)

Examples of some of the statements Teresa made at this time follows:

> But then you get six to ten sessions I think before you're cut off. [And her psychiatrist says] we'll just get your doctor to keep going on the drugs, and, and I

just, I felt like I was being thrown overboard... I wanted to tell them I, I'm scared, I'm not ready for this, please help me, but I, I just couldn't. (Teresa)

It is interesting to note that Teresa was unable to tell her psychiatrist how she was feeling and what she needed at this time. Also, the language she uses is negative as well: "before you're cut off" and "being thrown overboard." Other pertinent examples of negative language she used at this time follows:

> [During a home visit with her doula, Teresa said], I'm going to be a failure, I can't nurse my baby, it's too much pain.

> She was a good baby until about four months. Then she started teething, so that was a whole other ball game....I'd get 20 minutes off, we'd have to change her and everything, and then I'd have to nurse her again.... I had no break with the baby. (Teresa)

The mother's voice is empty, as in the above examples when Teresa "wanted to tell them, but just couldn't" and Andrea, "just didn't know how to answer her." For Denise, this empty voice manifested itself into doing things on a daily basis that she did not want to do and this lead to a deepening of her depression:

> I couldn't get it together enough to even say we're going to go to the library today, you know, like I couldn't even get it together enough for that. We were just home all the time where I didn't want to be. (Denise)

As Andrea begins to move through her depression, her language changes from being negative to becoming filled with anger, which is what is needed in order to help her move through her depression (PPPSS, 1997). This anger can be 'felt' in the next example:

> Like how much do they expect from me? I'm doing more than is humanly possible. You know, I have still a business, and taking care of [new baby], and it's like I only really get to work when she naps, you know, and then I have to do everything. Like the whole time since she's been born, not once have I ever laid down and slept while she slept. And, you know, it's just like, I, I keep saying these words, I keep saying this is what I need, and it's like it bounces off. They're not hearing it. It's almost like they don't want to hear it! (Andrea)

The energy retrieved from this anger can be utilized to propel the mother into the next stage –*Finding Herself.* In the *Finding Herself stage,* the mother's language, in this study, was more positive and reflective as she feels herself gaining more inner power. Her voice is calmer now. The reflective qualities of this stage are what set it apart from the other three earlier stages. This reflectiveness can be perceived in Denise's words. She was contemplating the reason for her depression which "was partly working through being a mom at home because it was the first time (she'd) ever not worked." In the next example, you can notice Rene coming out of her depression from her choice of words and how she describes her circumstance:

> By the summer she was pretty well sleeping through most nights, and occasionally she would get up. But, you know, again I'd just go in, you know, go back to sleep, and that was it. So by the summer it was, it was so much better… I went to see my doctor and I said you know, I want to go off the Zoloft (antidepressant) now… She's starting to sleep through the nights now and I …want to get off it, and hopefully try and get something going with my husband

> again. (M: Um-hmm) Rene: ...because I know that the Zoloft also just kills any kind of sex drive whatsoever. So you know, I slowly weaned myself off. (Rene)

At this point, Rene is sounding more sure of herself and is 'taking the lead' with respect to her medical care: "I want to go off the Zoloft" and "I know that..." and "I slowly weaned myself off." This self-confidence can also be noticed in Teresa as she reflects on her development:

> And now I took some classes this year, and I, there might be a 150 people and if I have a question I don't care if it sounds stupid. And people would come up to me after and say good question, I was, I was wanting to ask that but I was too embarrassed so I have that confidence that I've never had in myself.... And it's kind of like dealing with, that we all have this inner voice in our head that's our critic.... And I learned to shut that voice off. (Teresa)

In the next example, the reality and acceptance of a situation can be 'heard' yet there is still some hesitancy, should she ever be faced with PPD again:

> It's never normal when you've got kids, but it hasn't been too bad since then. You know, there are still ups and downs and, and things like that, but it was those, those first two years were the worst. And ...I, always said to people, I said, you know, if I had had her first and went through that, I probably never would have had a second kid. (Rene)

The above quote is a good example of the difference between the *Finding Herself* stage and the *As Herself* stage. A mother may move from this comfortable place in the *Finding*

Herself stage, where she feels she has recovered from her PPD, to an *As Herself* stage of development. This was the case for one of the mothers, Denise, in this study. The difference here, is that there is no longer any fear about having to face PPD again should the "nightmare" return with a subsequent birth. The mother here feels that she has learned about herself, her warning signs about when she needs to access help, and then how she can help herself as needed.

> (M: How do you feel now, Denise? Do you feel you might have another one?) Denise: Bill's not too thrilled about the idea. But, I mean, I wouldn't plan on a fourth one but if we became pregnant it would be okay with me.... I wouldn't worry because I know that I'm all right.... And I know my symptoms of what I get to be like when a depression is coming so I can spot them right away and I can get the help or, you know, more time for myself, or, you know, even go back to the Paxol (antidepressant) if I needed to. (Denise)

In the above example, Denise is both reflective ("I know my symptoms of what I get to be like when a depression is coming so I can spot them...") , positive about her future ("I wouldn't worry because I know that I'm all right"), and wise ("I wouldn't plan on a fourth one..."). In addition, throughout the quotes from Denise's transcript there is laughter as she tells her story. This is the aspect of voice that separates the *As Herself* stage from the other four.

To summarize, the elements *language* and *voice* are developed from birth and are influenced by the child's caregiver (Vygotsky, as cited in Goldberger, Tarule, Clinchy, &

Belenky, 1996). As the girl becomes a woman, her inner voice and corresponding language development also matures and parallels that of her self-identity.

In this study, language in the *Herself for Others* stage is emotionless, and her inner voice is being denied. From here (*Herself for Others* to the *Losing Herself* stage), her language becomes negative as her depression deepens, and her inner voice becomes depleted as her depression peaks. All her energy is now in survival mode, and will eventually becomes harnessed for her inner self as the anger begins to build and propel her into a place of recovery as she enters the *Uncovering Herself* stage. In this stage, her language is full of anger, and her voice now has energy. From here (*Uncovering Herself* to the *Finding Herself* stage), her language becomes positive and reflective; her voice is now calm. This is a place of comfort, and many will choose to remain here and feel satisfied. Finally, a limited few may further develop and enter the realm of the *As Herself* stage. Just as with the *Finding Herself* stage, the language the mother uses is both positive and reflective, and her voice is calm; however, there is now wisdom in her words and reflection. Moreover, the hallmark of this stage is that there is now laughter in her voice as she reflects and shares about her experiences. The third element, *perception,* will now be considered.

Perception

The *Canadian Oxford Dictionary* (1998) defines the word *perception* as "an interpretation or impression based on one's understanding of something (p. 1079, item 3). In this study, the mother's perception changed from being narrow in focus to being broad with respect to her worldview. An example of a mother's perception as she moves through the stages will now be explicated.

In the *Herself for Others* stage, a mother's perception is hers alone, and may not necessarily be shared by others:

> It was really something… I nearly died. I mean, that is in the back of your mind. Even though, oh yes, you're in a hospital, you know, with modern facilities, and the odds are slim, but people still do die, you know, in childbirth. It's not unheard of. And, but nobody wanted to talk about it. (Andrea)

In the next example, Andrea provides a poignant description of her perception upon returning home:

> It's like you're this appendage in the picture. Just a pair of boobs that follows [new baby] around. Yeah. That is how I felt. (Andrea)

In Teresa's case, her perception, interestingly, was greatly influenced by the media:

> I thought I was a failure because I didn't have the baby the way I should have…. I mean, you're watching TV and, and I didn't realize, I though you kind of went into labour and you had your baby. I mean with your first pain you've got to rush to the hospital…. Like someone goes into labour on TV, they grab their baby, and they're in their car and they have the baby. Or they have the baby like the first cramp, and the next thing you know the baby pops out…. And I think you're just, it's ingrained in society. You know, you see people on TV and movies, they come home with their baby and they're so happy and everything is perfect. (Teresa)

The shock of reality, of what labour and birthing can be like, was accentuated for Teresa, and likely propelled her into the *Losing Herself* stage. In the *Losing Herself* stage, the mother's perception is both negative and hopeless as her depression accentuates:

> I felt like I was just screaming out into the darkness and no one was coming, … or I was drowning and people were standing on the shore just watching me drown because I was begging for help (Denise)

Although they were in the midst of becoming bankrupt, Rene perceived that her husband was trying to avoid being in contact with her:

> And so you know, I didn't know anybody…. So, I spent most of the days by myself, and you know, my husband was really, really busy, you know, he was always working. You know, lots of evening meetings, and I think part of it was just to get away from me. (Rene)

While the mothers, in this study, were feeling deeply depressed, their perception of their world and what they perceived others were saying or thinking about them were greatly thwarted:

> It's sort of like I ceased to exist for people,… and if you say something then often, you know, well you're just being selfish and you're jealous of the baby (Andrea)

As the mothers, in this study, left the *Losing Herself* stage where they were feeling deeply depressed and moved towards recovery in the *Uncovering Herself* stage, their perception became more positive, and they began to consider their affect on others:

> And I remember telling [counsellor] that I was worried about [oldest child] mental health [laugh] because, you know, I was just from the depression, I didn't want to have anything to do with him, so I'm sure I pushed him away emotionally, you

> know, and he could sense that. So of course he was coming to me more, and more, and more, and it was sort of this cycle that I would push him away, and he would come more because he needed me. Right? (M: Yeah). Denise: And, yeah. So anyway I was saying to her [counsellor], so I'm worried about, you know, these things that I've said to [oldest child], like just the ranting raves that I would go in. I would tell him he was stupid, you know, and then I felt so bad. But at the time, that's all I could do. I just wanted him to go away. [Laugh]. (Denise)

Perception in the *Finding Herself* stage continues to be more positive. In addition, the mother's perception begins to set the foundation for her to encourage and forgive herself as she begins to have more good days than bad days:

> So anyway, I feel like I'm 80% Denise, and [laugh], you know, like not a 100%, that's how I felt, but I feel so much better than I felt at the time. And I feel better about, you know things I say to Bill, this is the baby that's given me the confidence that I needed. (Denise)

From here, the mother's perception may continue to evolve. Just as with her perception while in the *Finding Herself* stage, she continues to be able to forgive herself. However, the *As Herself* stage differs from the *Finding Herself* stage in that she is now able to be accepting and open to critical reflection from others:

> And of course he doesn't know what I need unless I tell him, so, you know, we were both quite frustrated. [Laugh]. You know, because I wasn't getting the support, and he was having to deal with this cranky wife all the time. He didn't know how to help me. Like if she would just say what she wants, then, you know, I'd be glad to do it.... Yeah, so I felt pretty good. And I keep asking Bill, how am

I doing, how am I doing? Do you see any signs? [Laugh]. And he says no, you seem fine now. So yeah, so. But it still is important to talk. (Denise)

In this last example, I am reminded that it takes courage to be truly open to feedback and critical reflection from others, especially, when quite possibly we may be at risk for receiving feedback that most mothers would rather not hear.

To summarize, the element *perception* is initially narrow in focus and eventually broadens to include and be open to other world views. To begin, the mother's perception, in the *Herself for Others* stage, is hers alone and is not necessarily shared by others. Her perceptions then become more negative and hopeless as she moves into the *Losing Herself* stage. The mother's energy then begins to build and is channeled into self-recovery as she begins the work of the *Uncovering Herself* stage. From here, her perceptions become more positive and encouraging. She also begins the process of forgiving herself for things she has said or done while feeling depressed. Finally, for a rare few, there may be further evolvement whereby the mother's perception continues the process of forgiving by now forgiving any wrongdoings that were done to her perhaps during childhood or present day relationships. However, the hallmark of the *As Herself* stage is that she is now open and accepting of critical feedback and reflection from others now that she is stronger and has gone full circle in her development of self.

Locus of Control

Locus of control refers to the degree of internal power the mother had or felt she could access at any time. In this study, the degree of shelter, as in the creation of a building, was used as an analogy to explain how much *locus of control* a mother feels while in each of the stages.

Just as in the building of a structure for shelter, the mother's *locus of control* is non-existent or buried in the *Herself for Others* stage. The ground or foundation for the building must be prepared. There are layers separating her from the outside world which have been building over the years in order to protect her inner self from becoming vulnerable and perhaps destroyed. As her depression peaks and she begins to spiral down more quickly, the layers that protected her inner self from the outside world become weakened. In this way, as the ground or foundation is being prepared for the creation of a building, the ground too becomes weakened as the earth is pummeled and set for the foundation of the building. It is now, within the *Losing Herself* stage, that she feels exposed and vulnerable to the outside world. Fortunately, though, the foundation to become stronger and more resilient is set and her energy will soon be utilized to move forward into the *Uncovering Herself* stage.

This energy is contingent on key variables that will determine how quickly she moves forward; in addition, it is these same variables that may determine why some mothers live with PPD longer than others. In this study, these key variables (reflective and intuitive abilities, outside resources) will assist her from the *Losing Herself* to the *Uncovering Herself* stage. Just as the building is being created, it may have the appearance of a lean-to structure until more resources are available before a more substantial building can be created. The same too is occurring within the mother's inner self–her internal *locus of control*. As the resources build and develop, the lean-to becomes a shelter (*Uncovering Herself* stage).

This shelter represents a solid building that may meet all the needs of the occupants. The same is true for the mother whose internal *locus of control* feels solid and

resourceful. Although some shelters feel like a home, it is not until the occupants of this home have grown and developed their own understanding of what feels home-like for them. This is the kind of feeling that cannot be 'bought' by the front window of a home furnishing store. Instead, the shelter may now simply exude a comfortable and home-like feel to the place because of the people who have created it. A similar process is occurring for the mother who moves from the *Finding Herself* stage to the *As Herself* stage. The mother now feels at home with her inner self, and knows she can return to that place when she needs to feel rejuvenated and well-grounded or needs to guide others in need.

Immediately postpartum, Andrea's internal *locus of control* was diminished as she felt pressure from her family to meet their expectations –an example of being in the *Herself for Others* stage:

> I guess, you know, because they were overjoyed with [new baby], and it's a happy thing. Everybody wanted to be happy. (M: Um-hmm). So there was this pressure on me to, to be quiet from the family I guess. So that was immediately surrounding the birth. (Andrea)

In addition to feeling pressured to behave in a certain way immediately postpartum, Andrea felt she had no choice at times –her internal *locus of control* was buried:

> And I guess he didn't realize how much it costs to pull off this quote, unquote miracle, I'm using his [her husband's] words. (M: So what would your words be?) Andrea: Well, just having to make it happen, you know, not having a choice in the matter. Something has to be done and things have to work, deadlines have to be met. So you don't have any choice, you just make it happen as best you can.... But yeah, I just had to go back to work, and, you know, there was the house to

take care of, and [new baby] to take care of, and there was just too much. (Andrea)

For Denise, her eldest child became a daily reminder of how her internal *locus of control* was indeed buried because she felt she had no choice but to remain home as an 'at home' mom –her *locus of control* (inner self) became more concealed as the days past: "I resented [oldest child] because I saw him as the symbol of my being at home, and I think that's why I started with my, with my fall to the depression." Denise follows with an example of how this was so:

> And then especially in the winter we would just go out for the whole day because I just couldn't stand to come home to the house and be alone with the kids. You know, like we would go to McDonald's for hours [laugh], and I would buy them a lunch and even go in the morning and just get a drink for them and he would go and play on the play equipment, because I just couldn't be at home.... I would do that a lot just because of him; I'd like I did it to entertain someone else when I was there.... I'd wake up in the morning feeling like I hadn't slept, and I'd have this sense in the morning that I wanted to roll over and cry because I'd think I have to do this for eight hours, I don't want to do this all day. And it's not, it's ten hours.... There's no breaks or anything. And so I'd wake up in the morning and I'd just cry because I though what am I going to do with this kid all day long, you know. And I think it was that I was bored [laugh].

As the days progressed, her sense of self became more deeply buried, and subsequently, she was also becoming more deeply depressed. The degree to which a mother, in this

study, feels she has no choice is what eventually determines where she is within the five stages. In the *Losing Herself* stage, the degree and reminder of a lack of control is accentuated and is highlighted in the following two quotes: "So I couldn't work… until my landed immigrant status came through" (Denise). After this set back, Denise incurred an additional one that likely caused her to feel even more depressed. While traveling with her husband and their three-year-old child, Denise was enjoying their visit to Ireland away from her in-laws, but this soon changed as they spent the remainder of their trip at a family reunion in England for her husband. She had recently given birth, and all she wanted was to be home once again:

> Yeah so we took to England and Ireland, and I enjoyed the first part, it was to Ireland, and then when we went to England it was, it was hard because you were in one spot for a long time, and I didn't really know anyone except for, you know, like all his brothers and sisters. And, and I just didn't enjoy that part as much as when we were in Ireland. But yeah, so that was the start of it.… I just was having a hard time there. Like I thought I want to go home and it (PPD) was beginning there I think. (Denise)

Teresa summarizes what an internal *locus of control* at the *Losing Herself* stage is like: "And I just felt a lack of control over my body and no freedom." From this point, a mother's LOC begins to get stronger as the energy from her anger helps her to regain control over her body and her sense of free will. A temporary lean-to structure is now established while she gathers up the resources she will need for recovery from PPD. This process of summoning up the energy and courage she needed to tackle her challenges is evident in Teresa's words:

> And I feel fortunate that I stopped that cycle or I'm trying to stop that cycle and I'm never going to have her feel not loved. (Teresa)

The same is true in Andrea's case as well:

> And well, but it's better simply because I can take care of myself more, which is what I was doing or which is what they always expect, but it's not what I want. I don't want to have to make lists for people and tell them okay, you've got to do this, you know, you have to give me more respect. (Andrea)

In the *Uncovering Herself* stage, the mother is beginning to make choices based on her free will and she feels more in control of her life situation. This sense of control is evident in the next example as Denise reflects on a conversation she had with her sister-in-law about herself:

> And it wasn't until [sister-in-law] said something that I realized that it was depression... After [sister-in-law] talked to me I thought she's right, I'm not myself, and I made an appointment and I went to see my doctor. (Denise)

This reflective ability, that was present at this time with Denise, was the key variable that moved her forward towards the *Finding Herself* stage.

The reflective stance of the *Finding Herself* stage is echoed in the mother's internal *locus of control* at this time. For Teresa she now felt stronger and more in control, and therefore, prepared to search for her birth parents:

> So I was adopted too as a child, so I'm searching for my parents, my birth parents now. (Teresa)

Locus of control in the *Finding Herself* stage also is about questioning present circumstances, and sussing out whether this is the right fit or not:

> Most days I'd be fine, but some days I really questioned if it was the best thing for me to stay home all the time, so I'm really excited to be going back to work. And I think a part-time job because that would have given me the balance between talking to adults and [laugh] being a professional person and being a mom. (Denise)

As the mother's internal *locus of control* in the *Finding Herself* stage, in this study, builds and becomes stronger, she begins to feel more rewards from trying out this 'new and improved' sense of internal control over her life. As a result, she begins to rely on herself more consistently for guidance:

> I got such a sense of accomplishment from that (goal setting) that I would go on to doing something else, but I didn't have to. That was the thing. Like I could stop after that one (goal), if I felt like doing more that was fine, but I didn't have to do, to do all four or five things. (Denise)

With respect to the *As Herself* stage, there is a shift that occurs with the mother's sense of her internal *locus of control*. Before, she would feel satisfied to consult a specialist, for instance, about her health care; now, she assumes the responsibility for her care and the decisions she needs to make for health and autonomy. An example of this follows as the mother decides to stop taking her antidepressants and discovers she feels fine as a result of her decision:

> And I didn't even phone her [doctor], I just started taking 20 (milligrams of antidepressant) again because I just knew. And so the next time I went into see her, you know, with one of the kids or something, I said oh, by the way, I'm back up to 20. She said okay, so she made the notes. But then in April I'd been feeling

> really good again for a couple more months, and ... so I went down to ten, and I had all these really physical withdrawal symptoms, and I think the ten milligrams was just maintaining like this withdrawal or something. Like I had the buzzing, and the telescoping, and all that sort of thing, and I thought all I'm doing is maintaining these physical side effects, and I didn't have any of the emotional sort of things, so I stopped taking it all together. Like from the ten, I just stopped taking it, and, and I've been fine since (6 weeks later after cessation). (Denise)

To summarize, the mother's internal *locus of control* is buried to begin with and then shifts as she moves through her depression. This shift results in a stronger more resilient inner self –an internal *locus of control* that she feels at home with.

Within the detailed perspective of the stages of *Becoming Herself Through Postpartum Depression* (see Figure 2-2), the mother's internal *locus of control* at the *Losing Herself* and the *Uncovering Herself* stages has been expanded and includes two more factors: 1) *universally experienced feelings*, by each of the women in the study, while living with PPD that are related to their diminished and exposed *locus of control* in the *Losing Herself* stage; and 2) *strategies* used by the women in this study while their feelings of power and a stronger internal *locus of control* were developing in the *Uncovering Herself* stage. These two factors will now be explicated.

Universally Experienced Feelings

For the women in this study, there were universally experienced feelings voiced which mirrored that of other women who have lived with PPD, and these were: exhaustion, feeling isolated, having irrational thoughts, a feeling of going crazy, feeling

stressed, an inability to process, retain, or concentrate on information, tearfulness, anger and rage, and wanting to escape (PPPSS, 1997; Sebastian, 1998).

Exhaustion. Denise describes her feeling of exhaustion well:

> So anyway, exhaustion. I had, I just like I'd wake up in the morning feeling like I hadn't slept, and I'd have this sense in the morning that I just wanted to roll over and cry because I'd think I have to do this for eight hours.... And it's not it's ten ..., and there's no breaks or anything.... So there were lots of things that I used to enjoy, and then I didn't have the energy anymore to try them, or if I did try them it got to you know, like going for a bike ride or something, and it seemed like such an effort to get someone to cover for us, get the bike out, and then I'd be on the bike and instead of enjoying the bike ride I'd be thinking, you know, shit, I have to go home, there's a pile of laundry and the bathroom hasn't been cleaned.... And I was lethargic, I was sluggish, I didn't want to get out of bed, I couldn't dress myself. I could barely dress myself.... And it would take me two hours, you know, to finally get the energy together to get up, to get dressed, and go downstairs and face the day. (Denise)

In the next example, Teresa reminds us how caring for a newborn baby in the first few weeks can be exhausting:

> And also you're exhausted. You're nursing every hour. By the time –because she'd nurse for 40 minutes, and I was supposed to nurse her every, because she wasn't gaining her birth weight back fast enough, so they, I'd have to, they wanted me to nurse her about 12-13 times a day. So you know, starting at about maybe six in the morning and going 'til whatever, bedtime, and then maybe once

> or twice at night. So it, it was draining because she'd nurse for me for about 40 minutes, I'd get 20 minutes off, we'd have to change her and everything, and then I'd have to nurse her again. So it was just, I was exhausted. (Teresa)

As the baby gets older, and her feeding pattern begins to settle, her sleeping pattern may also begin to settle; however, this is not the case when the mother has a colicky baby who cannot settle comfortably leaving no reprieve for the mother:

> It was still sleep deprivation because she was still getting up every two or three hours every night, all night. So I never got a good night's sleep, so I was chronically, you know, sleep deprived for the first two years after she was born.... So it wasn't until like last spring when she (two-years-old in the Spring) had one night where she actually slept through the night, and it was like, well I still kept getting up because I kept going did she wake up, did she wake up, because I was in this pattern of getting up and down all the time. (Rene)

Finally, Andrea gives us a glimpse into her reality and the reasons for why it was just so challenging to try and get the rest and sleep that is so badly needed postpartum:

> I wasn't really really capable of working for the first two weeks. You know, and it's not like you have a lot of sleep.... It was also very noisy during the day, so I couldn't really nap. I just kept getting woke up all the time. So when Leah did nap, I didn't get any sleep. So there was really only about three hours a day that I could sleep. But eventually, you know, paper work from the government arrives and you have to, and I also had like a Christmas craft fair that I had already committed to that I had to do in November, which was about six weeks after she

> was born.... The reality still hits when you come home, and where, where are you left with that? And yeah, like, you know, a place where mothers can actually go and say well, you know, no, this isn't right and yes, I feel like just offing myself just so I can get some sleep. (Andrea)

Feeling Isolated. The mothers in this study felt isolated primarily for three reasons: not feeling physically healthy, not having friends or family around, and not being able to get out of the house because of transportation issues. All of these factors are related to the mother feeling a lack of control over things she cannot immediately change. Teresa had a Caesarian section and this challenged her physical health for about two months. As a result, she felt isolated since she was unable to leave her home:

> I started feeling better physically about two months after.... We lived in a house where you had to go up maybe six or seven cement steps to get to our door.... So that really held me in too, because even when I was feeling more up and about, I couldn't lift the stroller down the stairs. I didn't want to leave it out because we didn't live in the greatest area, and I had ... to get the baby ready, get the baby out of the house, she's screaming, go and have to lift the stroller down the stairs, it took me quite a little while before I could do that and just go for a walk out, around the block. (Teresa)

Physical health, as Teresa demonstrates, has an affect on how isolated a mother may become. The second factor, not having any family or friends around is another consideration that leads the mother to feel lonely and isolated. For Rene, this isolation factor played a large part in her remaining depressed:

> I had no brothers, or sisters, or parents, or anything around to help, and really I still didn't really have, you know, any friends because we were only in Victoria for five years.... And so, you know, I didn't know anybody.... I spent most of the days by myself.... I was by myself, and I think that just made it worse, you know, not having anybody around. (Rene)

The third reason why the mothers in this study felt isolated was due to transportation issues. In the first instance, Teresa was unable to drive a standard, and in the second example Andrea did not have a car available for her to use during the day, and there were no grocery stores or areas of interest within walking distance from her home. This lead both women to feel isolated:

> And I couldn't drive a standard, our car is a standard, and I couldn't drive the car, and you know, I was really isolated. And [obstetrician] said, you know, I said I don't know how I can go see this, this [counsellor] person because I can't drive to Oak Bay. I don't know if I can handle her on the bus going. (Teresa)

> You can't get out of the house and get groceries since you don't have a car, ... you don't have transportation, you don't. (Andrea)

Irrational Thoughts. Irrational thoughts can range from being debilitating to being horrific as will be shown:

> I often had all these ... thinking –I remember talking to somebody once. I'd had these thoughts of, weird, weird thoughts. Like I'd... my mind would be carried away thinking what if one day I had a heart attack here, and here's my kids,

> they'd be trying to wake me up, and I'm lying down on the floor, and it's like oh, my God, what would happen to my kids? And nobody would know because, you know, my husband doesn't usually call during the day, and I don't have friends or neighbours that call on me regularly, and I could lay dead on the floor for like eight hours before my husband came home, and what would happen to my kids? You know, they'd sit there and they'd cry and scream all day and nobody would hear them, and no one would be able to look after them. And, and I'd get myself all worked up saying don't think like that, it's stupid thoughts.... I'd have all these thoughts of, you know, things happening to me and my kids being left alone. So you know, things like that, it would drive me nuts. (Rene)

Irrational thoughts have been differentiated from the next feeling, a feeling like she is "going crazy," because the mother qualitatively separates the two. The first feels relatively controllable and transient, whereas, the latter feels out of her control and a new permanent way of being.

A Feeling of Going Crazy. "I thought I was going crazy.... I felt like I was going crazy, and if I told the doctor or whatever I'd lose my baby and I'd be called a bad mother or things like that." (Teresa)

> You know, I thought I was a crazy person just because –I was told that as a child, and I thought there it is, it's happening, I'm going to be carted off to the mental hospital. Like I was so afraid that as soon as I'd say this they'd admit me to Eric Martin. (Teresa)

The next feeling to be discussed is *stressors*. Stressors are differentiated from the aforementioned *triggers* because triggers are unique to the woman involved and are not

necessarily universally experienced stressors –such as the trigger of a Christmas Craft show for Andrea. Instead, stressors that are more commonly expressed by women living with PPD are mentioned here.

Feeling Stressed. A source of stress may be found with some family and or friends who have good intentions, but end up causing a lot of discomfort, stress, and grief for the mother with PPD. An example of this follows:

> My father, you can never do right by him, you know. So yeah. He always finds fault with something. I mean, I'd joke with my friends about the jibe of the month after I'd talked to him. He's got to come up with something to insult me. It's just, he's not happy unless, you know [laugh] … unless her comes up with something. He wasn't very happy about my getting pregnant, and I knew that, and so I, I, knew he wouldn't be happy…. So I didn't even tell him that I was planning on getting pregnant. I really didn't want his interference… I wanted it to be a happy occasion (Andrea)
>
> But afterwards, you know, she [mother-in-law] basically didn't help much. You know, she always expected me to spoon feed her, and I wasn't capable of it at that time. I wasn't capable of making a long list for everybody and saying that they had to do it. So she didn't do much. I ended up doing laundry, and, you know, taking care of [new baby], and … emptying the garbage baskets, and all sorts of stuff when I really shouldn't have been bending down. (Andrea)

Another stressor that is universally experienced by military families is the reality that the spouse could be called into service, at any moment, with little notice. The call to

duty could very likely be for a long time and regular contact is not possible or is greatly challenged. This was the case for Teresa, and her husband Mark, shortly after their first baby was born:

> My husband was home for the first few weeks, and then there was stress because he was in the navy at the time, and he had to go … to Guam for eight weeks, and I was crying again over that because I thought I can't even stand up to change her.... [About five months after the baby was born] he came home from work one day and he said in 10 days we're leaving for East Timor for six months; we were just told today. So it was just, it was devastating for us.... And it was really, really hard. (Teresa)

In situations when the mother is feeling stressed and exhausted, beginning to have irrational thoughts and wondering if she is going crazy, it is understandable that her cognition would be affected in some way.

Inability to Process, Retain, or Concentrate. Not surprisingly, mothers may find themselves forgetting things, and not being able to concentrate when they are feeling stressed and exhausted, or on the verge of tears. However, once the mother realizes that she is unable to do the things that she used to enjoy like creative writing or reading the newspaper, these seem to lead her further into her depression and her sense of an internal *locus of control* would be reduced:

> I couldn't concentrate on anything or focus on anything. I stopped balancing our cheque book because it just was so overwhelming.... So I'd put it away.... I remember one day the newspaper, like we get the daily newspaper, and I, I was afraid of it. Like it's really weird, but I was afraid of it because that was the thing

> that made me realize that I couldn't focus.... I'd get to the end of the paper and nothing had stuck. I started to be afraid of it, which sounds really weird, but it was because, it was the symbol to me that something wasn't right, you know, and that I couldn't process, I couldn't retain information, I couldn't concentrate on what I was reading. And there were just so many pictures and so many articles that I found that overwhelming too. (Denise)

In the next example, Andrea tells us that she made an effort to carve away time to nourish the creative part of herself; however, she discovers that this part of herself was gone, and instead of replenishing or nourishing herself she became more depressed:

> One day I actually got away in eight months, and it was to a romance writers' group in Nanaimo because I like to write. And I went with my friend ...., and we did this exercise on writing a scene. And you're supposed to take all these pieces, and you write them down, and then you connect them later on. It's like connect the dots. And it's interesting what you come up with of your subconscious, but just trying to do something like that. Something that would have come so easy to me, didn't. It's like I hadn't used that muscle for so long that I almost didn't know how to even, and that made me really sad. (Andrea)

Tearfulness. Inarguably, crying is a universally experienced emotion by all women with PPD. The feelings of sadness, helplessness, hopelessness, and depression are expressed through tearfulness or crying, and the mother may find herself crying "for no reason:"

> I cried a lot for no reason [Laugh]... and there'd be a little thing, and I'd be in tears. (Denise)

The same was also true for Teresa:

> I kept saying to Mark, I'm still crying, what, what's wrong with me?

At times, Teresa understood why she was crying and felt it was a natural thing to do considering her husband was just posted:

> I lay on the floor and cried some days. I'd just feel so helpless; I'd just lay on the floor and cry. Like it was really, it was really hard on me. And so, and then my husband was gone… and naturally I was crying all the time because I was trying to struggle and do this by myself. (Teresa)

Rene managed for 6 weeks before she found herself having a good cry:

> It was six weeks after, when you go for your six-week check-up and I, I was really upset, … and I broke down. (Rene)

Once Teresa started on her antidepressant medication, she found she lost this natural ability to cry, and she missed it:

> I was never crying because the Paxol kind of took that away from me but I'd feel down and depressed. You know, sometimes it's almost better to have a good cry. Like I'd want to cry sometimes, but I just couldn't. (Teresa)

This inability to cry or release intense emotions could lead to anger, and for some even rage.

Anger and Rage. The anger a mother feels while she has PPD becomes a concern not only for herself, but also those around her. Anger could be a blessing in disguise as it can become a clear sign that she needs help:

> I was angry a lot and I was very sad. And he [husband] would go off to work, and he would be concerned about leaving me with [oldest child] and [new baby]

> because he was wondering, you know. And I think ...there was just a strong concern he said. And then one day I was, I don't even know what happened, but I slapped [oldest child] and Bill was there, and he said that was the day that he knew, you know, something's very wrong. (Denise)

Teresa also felt anger, and this anger changed into rage, but it still remained after she started to have more good days than bad:

> One day I was so filled with rage and so overcome, I went in the kitchen and I slammed the cupboard door... I had this violence building in me and that was my way that I wasn't hurting anyone. I'd take the cupboard door and this loud banging, ... and I slammed the cupboard door. And then that day I slammed the cupboard door and my...back cupboard's open and I have the wine glasses on top. I broke all my good wine glasses because they were really close and they all broke, and I though I need help... I was scared for her.... About a month later I went to my doctor and, and she asked was it any better. And I said well, I was happier, I was getting more rest, and my husband was home.... But I said I'm still feeling the rage and the anger. (Teresa)
>
> Sometimes she'd be crying, and you'd feel that urge to just stop it, you know. Like I, before I had [new baby] I thought oh, those are evil people that shake their babies, you don't shake your baby. You know, I'd hear things on the news and I'd think they were horrible, evil monsters that did this. And then I'm having those same feelings. It's scary, but it's very real inside you, that rage and that anger. (Teresa)

Wanting to Escape. The last universally experienced feelings that mirrors that of other women who have lived with PPD is a feeling of wanting to escape. For some, it may simply be a wish to leave their present situation and get away for the day, and for others it may even be thoughts of their life ending in order to get away from the pain of living:

> I'd want to pack my bags and leave for Mexico. You know, like things that you're not supposed to say ... because you're afraid. If somebody hears this, oh God, you know, they'll come and take your kid away (Andrea)
>
> (M: Did you ever feel like hurting yourself?) Andrea: No. Mainly just feeling like I needed to escape was more the sensation. Like I was just, just so at the end of my rope that I just wanted to scream or just do something, anything. I didn't know what it was. You know, not necessarily violent, I mean, not violent. I, it was just, it had to stop. The stress was just so much.... But sometimes it, it did cross my mind sort of ... if I could just die and it would just end, or if I could just, if I could just stop. Please make it stop. Is, was the sensation. (Andrea)

Although both Andrea and Rene (having a heart attack) had thoughts of "if they could just die," suicidal ideation was not a daily reality. Teresa had thoughts of suicide, but she intuitively knew she did not ever intend to take her life:

> I wanted to get away from what was inside of me. Like almost, like an out of body experience. And sometimes I would say I feel like killing myself, but that's, that's not what I meant. I talked about it in therapy, and it was, I wanted to escape from myself because I didn't like who I was, and I just wanted to get out of this

> body and, you know, float around or whatever.... And everyone has days when they just want to leave, leave their home and leave that baby behind. (Teresa)

To summarize, there were universally experienced feelings that the mothers, in this study, lived through while they were in the *Losing Herself* stage. From here, certain key variables determine how quickly they moved forward into the *Uncovering Herself* stage. It is these key variables (reflective and intuitive abilities, outside resources) that helped them towards the road of recovery through their PPD.

Key Variables to Bridge from the Losing Herself to Uncovering Herself Stages

There are key variables, innate abilities that facilitate movement forward from the *Losing Herself* stage to the *Uncovering Herself* stage. These innate characteristics are an ability to be reflective and intuitive:

> And my doctor said I just needed exercise, and to get out and do more, and that kind of thing, and so I thought okay, I'm just not adjusting to being a mom and I just have to do that. You know, I just have to do it.... And ... my brother and my mom and dad came for Christmas, and my brother even said, you know, something's not right ... he said he was worried about me. And like, and if you knew my brother, that's just astounding. I mean, he would never say anything. [Laugh].... So, then I went oh, my gosh, if [brother's] saying something, well [laugh] something's really wrong.... I thought there is a problem here.... I thought I have to go now [make a visit to the doctor]. (Denise)

For Teresa, she intuitively knew she needed help once she reflected on her situation after 'hitting her wall':

> And then that day I slammed the cupboard door… and … I broke all my good wine glasses, and I thought I need help. I can't –even if they did something, even if they did do all those horrible things to me, I need help for my baby. I don't trust, trust that, what if I get worse some day? Like I was scared for her. I know I would never do anything to her, but at the same time I knew it wasn't healthy. (Teresa)

The last variable to be discussed that facilitates movement forward is the availability of outside resources. Examples of outside resources, meaning not an inner resource, are: having the use of a computer to access the internet for information, a family member who recognizes that something is not right, and other people, such as a supportive doctor, doula, politician (in Teresa's case), or counsellor to assist you through to recovery as needed. In the first example, Denise had access to the Internet and a supportive sister-in-law to assist her through recovery:

> I remember looking at one of the web sites after, like I was checking out depression and it had like the five stages of five levels of depression, and the fifth was like the suicidal thing or mentality, and I was number four. I had all the symptoms of number four. And I just started to cry because I thought what a horrible way to live. And you know, my sister-in-law, is the one that told me … you're not yourself and you need to go see your doctor. So, yeah. So I think you know, what do people do that don't have someone who cares for them, you know? Like I had no idea that I was depressed. Like it's such a sneaky sort of disease. You know, it just caught up to me, and then I had no idea that I was depressed

until she said something, like you're just not yourself. And then I thought about it and I knew I was. [Laugh]. (Denise)

In the last example, Teresa had a wealth of resources available to her, which she accessed, to facilitate her through her depression:

And maybe two days after we brought [new baby] home, my doula, my back-up doula ... and I said I, I can't breastfeed because it felt like someone was like trying to cut off my nipples or something. Every time she tried, it was so painful. My back, to stand long enough to have a shower, I'd be crying in pain from my back. So I started going, I went through massage therapy... which helped, and then I went to a chiropractor.... A few days later, I was panicking. Like I made Mark run out and buy a breast pump because I was afraid I was going to starve my baby. Just to have milk stored up that we could give her, because I, I'd feed her, when we came home from the hospital I'd feed her with a cup because I didn't want any soothers or anything. And it took ... all the way through my public health nurse was wonderful, coming to my home. (Teresa)

My husband was home for the first few weeks, and then there was stress because he was in the navy at the time, and he had to... go... but my doctor intervened and wrote a letter to the ship saying that I had, you know, complications from surgery and I'd needed, I needed my partner there. I wrote a letter to the Member of Parliament because they were really just yanking him around.... The padre said I'll recommend that you be dept off the trip. They didn't listen to that. They told us to see the base social worker ...and they didn't listen to that.... And so finally I said I'm writing a letter to David Anderson, our MP

> because just that day a newsletter had come from him when they say all the stuff that they've been doing, and I wrote a long letter to him explaining our situation, and kept track of all the things on what day the navy told him to so see a social worker. I kept track of it because I didn't think it was right what they were doing. (Teresa)

In the end, the MP was able to circumvent the navy's original wishes and her husband was returned home much earlier in time for Christmas. This long quotation was included as Teresa's experience was different from the other three mothers. Although she had a wealth of support and resources, she still continues to experience PPD nearly three years later. The other point to note is that the opportunity to have outside resources such as regular chiropractic, massage, and counselling appointments, as well as, regular visits from a doula and her back-up partner are unusual. However, I wonder what would have happened had Teresa not had these resources? Would the severity and length of her PPD be any different? Without these resources, might she have discovered and utilized her own innate abilities to heal herself?

To summary, the variables to help bridge the mother from the *Losing Herself* to *Uncovering Herself* stage have been delineated. Once in the *Uncovering Herself* stage, a variety of strategies can be used to facilitate recovery while the mother's internal *locus of control* is becoming stronger and her feeling of power is being refurbished as she uncovers herself.

Strategies To Facilitate Recovery

Certain *strategies* were utilized by the women in this study while their feelings of power and a stronger *locus of control* were developing in the *Uncovering Herself* stage.

These strategies were: *goal setting, using aids* (light-timer, template for reading, medication, a sleep plan), *emotional support, counselling, remembering communication skills* (with significant other, family, and friends), *time alone with their significant other* (babysitting swap), and pursuing previous and new *self-interests.*

Goal Setting. Goal setting was found to be a very useful technique, and accessible for all mothers. Goal setting ranged from small steps, like deciding to clean only the sink that day in the bathroom instead of the everything, to larger steps like deciding to admit that there is a problem and deciding to call and make an appointment with the doctor:

> And so I make the appointment that day, like right after I slammed the door. I said (to herself) I'm going to make the appointment (Teresa)

An example of how smaller steps to towards a larger goal was effective for Denise follows:

> I decided that I would do one project a day kind of thing. Like I felt overwhelmed by the housework, and by the childcare, and by the laundry, and so I just decided okay, I'm just going to do one thing everyday. Like instead of trying to get it all done, and, and there's always stuff to be done, right, so you never feel like they're finished. I'm just going to try and get one task a day, and even if it's just as simple as putting on the washing machine, you know, like my task, that would be my task for the day. So I would feel like I had made progress towards the goal or something, instead of trying to clean the whole bathroom, which was so overwhelming, just clean the toilet, you know, or just clean the vanity. [Laugh]. And then maybe the next day tackle the toilet, you know? But that was, that was all that I could cope with at the time. (Denise)

Denise gained a great sense of accomplishment after reaching her goals. This goal setting was continued and developed into a daily purpose:

> Like if we were out driving here or going there I had that sort of goal to do and I was fine, but if there was a day when nothing was planned... I would just cry.... It was having a plan to do things that made the days go better (Denise)

Teresa and Rene also found that having a purpose helped lift their spirits and helped the days pass by:

> You know, I've ... I always found that if I got out I felt much better. When I was at home, that's when, it affected me more when people weren't around because then I tended to, you know, yell at the kids more, and I'd cry more, and ...things like that. But when I got out amongst people, it kind of lifted my spirits. And when I was talking to people and ... just being out shopping or whatever ... I got into the habit of always going shopping. Like everyday, it's like what am I going to have for supper today, I've got to go shopping today... just to get out. (Rene)

For Teresa, her daily purpose began with walking, and later to lead into learning how to drive a car. As a result, her sense of feeling control over her daily life situation increased –a sign that her internal *locus of control* was also increasing as she moved towards recovery from PPD:

> I just walked everywhere. I walked up and down the street to get groceries with the stroller, and it gave me a purpose everyday to do my errands.... You know, I made an errand, oh, I have to get soap today, so I'd make a trip to London Drugs, and, because that's where I got my company. You know, because people would be so attracted to the baby and that was my human contact just to do that. (Teresa)

I started taking Young Drivers of Canada. [Counsellor] got me to go, but then I kind of got off it, and then [psychiatrist] and I did therapy around the reasons why I felt like I couldn't drive, and ... now I'm driving. I'm driving everywhere. (Teresa)

Using Aids. Aids were used to empower the mothers, in this study, and to facilitate recovery. The mothers in this study found the following aids particularly helpful: a light-timer, a template for reading, a sleeping plan, and at times medication that was carefully monitored:

> And this is just a really little thing but it made a huge difference for me. In the wintertime I put our living room lamp on a timer, and then so we would go out and, you know, the darkness is something that I had... a hard time with too. And we would come back at four or five in the wintertime and it's dark, right. You know, you come home to this dark house and ... so I'd put our lamp on a timer. And just coming back to light, I don't know why but it made this huge difference. Like suddenly I didn't mind coming back home again.... It made a big difference to me, just to come home to light. (Denise)

The other strategy that Denise found helpful for her inability to concentrate was the use of a template. This idea to use a template came from her experience as a schoolteacher:

> I remember in grade one there was a little boy that needed, you know, a, I called it a template, but it was a page, like it, you know, cardboard page, and he just cut out a little window, and that's all he would look at. And so you read through this window because to see the whole page was just too much. And I couldn't understand it but I was sympathetic toward it, and now I understand it. And that's

what I needed to read my newspaper, a little template, just a little window. Yeah. (Denise)

Both Teresa and Andrea were given a sleeping plan by their physicians and this made all the difference as they began to regain control:

In the summer I went to see my doctor and said, you know, I was grouchy and ... all bitter, and she, we came up with a sleep plan. And so I would get at least five hours of straight sleep at night. Like sleep in [new baby's] room for the first half, and (then) my husband would, would take care of [new baby].... and I was getting sleep. (Teresa)

The same was also true for Andrea after she went on a sleeping plan:

Getting more sleep really helped. And I was able to have, you know, that little bit more energy to cope. So things just got better simply because she got over her colic, and slept more, and I could put her down which really helped. (Andrea)

The last aid to be discussed is the use of medication. Medication came as a mixed blessing for the mothers in this study. Interestingly, all the mothers were prescribed an antidepressant, and used it at the beginning of their depression. Denise was on her medication for about 6 months. Rene decided to come off her medication after two and a half years. Teresa started to wean herself off the medication after about three years, and Andrea continues to take her antidepressant after two years. Once the correct dose and choice of medication was determined, the mothers had relief from their depressive symptoms. However, I wonder what would it have been like if the mothers decided not to

go the pharmacological route? Did the medication prolong their experience of PPD? Has adopting an antidepressant prevented them from discovering their own innate abilities to heal themselves and move through their depression?

Rene found that her medication (Prozac, and then Zoloft) inhibited her ability to sleep and "killed her sex drive" as we learned earlier in the transcript:

> A few weeks after I started seeing [counsellor] I went to my doctor and she put me on Prozac. And I tried that for a couple of months, it didn't do a thing for me. So it just kept me awake all night. I'd lay there all awake. And so she switched me to Zoloft, and then that seemed to help me.... I was still very sleep deprived, and Zoloft ... doesn't help you sleep, you know. I've heard that some people say... it helps you sleep and another one said it makes you sleep worse, (Rene found that) you can't sleep as good. (Rene)

Although Andrea is presently on an antidepressant, the process to finding the right dose and type of medication was difficult on her:

> And so I talked to my doctor, and she was kind of concerned that it hadn't gone away, but we were already going to keep a watch on it because I was prone to depression sometimes before that. So she gave me some medication, but I found that the medication made me sick. You know, it made me dizzy and nauseous, and that didn't help because I really needed all my faculties to even make it through the day. From morning until night. (M: So you stopped that, and then what happened after that?) Andrea: Well I just slept more.

This difficulty to find the right dose and type of medication left Andrea feeling angry and frustrated, and reflecting on the reality of the situation –"how much do the drugs help is you know what the problem is? The problems don't go away":

> The mother has to take care of the children, the mother has to take care of her husband, the house, a lot of work, it just goes on and on. And well, who takes care of the mother? You know, take these drugs, …take the antidepressants, …take the Valium, take the sleeping pills, just something, rather than saying well wait a minute, maybe this person is just doing more than they are capable of…. This is something that's beyond drugs. You know, there needs too be support for the mother…. And, but the thing is how much do the drugs help if you know what the problem is? The problems don't go away. (Andrea)

Emotional Support. Emotional support includes everything from having family and friends to visit with over a cup of tea to having strong mentor who understands what the mother is living through:

> I didn't have as many friends as I do now, just some more friends like to, to come by. But I was honest with them, and I liked it when they came over…. And I have more of a network of … friends through [new baby]…. And … we meet every week for tea, and we get together for dinner, and I just feel like I have so many friends now and I'm so happy with that…. And there has to be more open discussion about it (PPD). I find the friends that I have now … talk so openly about these things…. Nothing was ideal, and we talk so openly about our experiences with it. And I share with them what I've been going through. Not

> every personal detail, but they all know I have postpartum depression. I want to talk about it. (Teresa)

It is interesting to note that in the beginning when Teresa "didn't have as many friends" as she does now, she was 'losing herself' in her depression. Today, as she is begins to 'uncover herself' and come closer to 'finding herself' and recovering from PPD, there seems to be a direct relationship with the emotional support she receives through her friendships. I wonder which factor (PPD or friendships) played a major part in her recovery? Was it the fact that she was getting to know herself better and become a stronger person who people would be attracted to, or was it the emotional support that she was receiving through other means? Rene found her recovery much easier once she entered a support group for women living with PPD, and later a support group for moms in her parish community:

> On the first Thursday and the third Thursday of every month they has the postpartum support group at [counsellor's] office.... There were a bunch of other women that were also going through PPD.... I started that... and that helped a lot. Because you'd see how many other women were out there who were going through the same thing, and who needed to go on some kind of antidepressant because... you couldn't do without it. (Rene)
>
> And so of course [counsellor] knew about the group (Mom and Tots), ... so she'd given me [facilitator's] name and I started going, and that was my oh, yeah, Wednesdays, oh-ho. [Laugh]. So just to get out and be around other people, and just being around adults. Yeah, that Wednesday morning was my only being

around other adults in a week, so it was like no wonder I look forward to Wednesdays. I still look forward to Wednesday. (Rene)

This really helped with the isolation that Rene felt day after day. She also gained friendships through these groups, and has taken a turn being a facilitator for the same group she started in since recovering from PPD.

For Andrea, it was just wishing she could have someone to call when she was feeling down:

> You know, like you wake up and you're feeling crappy, you really need somebody to come over. Is there somebody you can call? Not all mothers have that because they don't have family ... available.... Or in my case, all my friends work. They can't come over. Yeah, ... they're at work. I can call them and they'll probably tell me to bugger off, and I don't blame them.... I think the support network for mothers isn't there.... You need a hug and you need loving too because of all this outpouring that you're doing all the time. (Andrea)

The value of friendships and support groups has been given. However, the immediate relief, and long-term benefits of having a mentor, who has lived with PPD or works with women who presently are living with PPD, needs to be emphasized. For me, this mentoring support came quietly one day when my husband's aunt came to the door to deliver a casserole and to see the new baby. She said, "You look like me 30 years ago." From that point on she came daily to sit with the baby so that I could get out into the fresh air with my husband. She also assisted us by quickly recalling the daily routine of caring for a new infant in order to assist my husband at this difficult time. For

instance, she quickly sorted out how to make formula for a hungry baby with my husband late one evening. She was also there for me at the other end of the phone 24/7. Even though I never needed to call, I knew she was there. And this made all the difference.

For Teresa, this mentoring support came in the form of professional services:

> And even when Mark got back… she had me coming in to her office every week just to talk to me and make sure I was okay. So that… was just wonderful. She was wonderful through the birth, through the breastfeeding, through everything. She was a big, big support. And with all these women along the way like my…doula, my backup doula, the public health nurse, my doctor, all these strong women helped me through it. (Teresa)

Receiving Counselling. All the mothers in this study received counselling. Each of the women also gained different benefits as a result of their counselling sessions. For Andrea, she was interested in "tools (anger management)… something practical… where the person can actually walk away with it, or… somewhere to go just to talk" (p. 16). In Rene's case, she wanted her counsellor to tell her husband what she was going through:

> He didn't know how to handle things. So we brought him in one day. [Counsellor] was trying to explain to him how I was feeling. (Rene)

After receiving counselling for her PPD, Teresa learned to walk away in order to control her frustration and as an anger management technique when she was unable to comfort her crying baby and had tried everything she could:

> I'm so grateful that I had the wherewithal … just to put her in her crib and walk away and close the door because she'd be safe in there and I could go and compose myself for a little while, and then come back and I could

> calm her down.... If I didn't get counselling I hate to think how I'd be treating [new baby]. It's scary but it's very real inside you, that rage and that anger. (Teresa)

In addition, Teresa received cognitive therapy to help her gain more self-confidence:

> And it (inner critic) would say, if you're speaking it would say you sound stupid, they're going to talk about you when you leave because you're stupid, or they're looking at how ugly you look today. I know they're thinking that or whatever. And I learned to shut that voice off... inside my head. I have so much more self-confidence now. (Teresa)

For Denise, the combination of the counselling with the antidepressant therapy is what she feels turned her around:

> And she [counsellor] was just wonderful. Like the two things together just turned me around. Like it took awhile, it wasn't like the difference between night and day, but it was sort of like you know, if you're at the lake in the morning and there's a fog and then it starts to burn off.... I felt more like myself. (Denise)

Communication Skills. If only everyone had better communication skills, the world would be a better place. This is where counselling can utilized as a resource to assist families in this area. As Andrea suggests:

> I think people need to talk about those (roles and boundaries). Like a grandmother acts this way, a husband acts this way, and a wife acts this way, whether it's right or wrong, but at least to be able to state ... rather than assume. (Andrea)

Good communication skills require one to listen while another can be sharing honestly how they are feeling. In the following example, Andrea understands, in hindsight, what would have made a great difference if she told her husband what was on her mind:

> Because you don't have the energy... physically or emotionally to deal with that relationship [couple], and now it becomes the responsibility of that other person to carry it for awhile. And it so happens in life, in all relationships, that it can't always be equal. Sometimes one person has to sleep more than the other, and to know that that is okay.... It's not going to always be that way. (Andrea)

Time Alone with Significant Other. Finding time alone with a loved one is challenging enough at the best of times, but after a new baby arrives home, this priority soon becomes long forgotten as reality sets in. Denise and Bill found a way to get around this dilemma after their second child was born:

> And we baby-sit for them (neighbours) and then they come over and baby-sit for us and we get out kind of thing, and it makes a huge difference because I feel like everything is me as a mom here, and somewhere I've lost me as a person, and then me as the woman that Bill loves. (Denise)

Pursuing Self-Interests. Pursuing new and previous self-interests seems to be one of the key strategies that help maintain the mother's sense of herself. It is interesting though, how easy it is to forget what it is you used to enjoy. I remember once my specialist asking me years later, "what do you do for fun?" I had no answer. I couldn't remember. Since then I have learned about the value of pursuing self-interests, and

Andrea has as well. When I asked Andrea about what she feels is important for recovery, she replied: "... getting time for yourself.... And you need a break, as much as you love your kid.

To summarize, certain strategies can be used to feel powerful again and build a stronger *locus of control* while in the *Uncovering Herself* stage. The strategies that were mentioned here were: goal setting and using aids –such as a light-timer, template for reading, medication, and a sleeping plan. Also, the importance of emotional support, counselling, and remembering to use communication skills with your spouse, family, and friends were emphasized. Finally, the benefits of carving out time alone for yourself, and with your loved one by pursuing previous and new self interests and through a babysitting swap was given. Next, the final element *relationship with significant other* will now be considered.

Relationship with Significant Other

In this study, the *relationship with significant other* begins as an avoidance type of relationship and eventually shifts into more of a couple type of relationship –new and improved compared to how the couple was before children. In the *Herself for Others* stage, the couple may feel "fine", but trouble is brewing:

> (At what point did Paul come back into the picture or cope, could cope with it better?) Andrea: It took months, months. You know, he just kind of oh, the birth is over with, [new baby's] here. He kind of went back to his old life. You know, well Andrea will take care of it, you know, Andrea always pulls off these miracles. Well no, I don't. And I guess he didn't realize how much it costs to pull off this quote, unquote miracle.

> (M: Were there other things that were going on during that time, when you were having the depression that you found challenging?) Andrea: My relationship with Paul… Because it's sort of like he was very helpful when I was pregnant, and her would make dinner, and he'd rub my back, and he'd asked how I am, make sure I ate… but afterwards he didn't. It just kind of stopped.

In the above example, Andrea misses the kind of relationship she had with her husband before the baby came, and then once the baby arrived he was gone. I wonder if the avoidance had anything to do with how Andrea was feeling at this time? In other words, she was not her usual self, yet she needed his support more than ever at this time.

For Denise, she was holding back, and being in a role for others since she was home and not "contributing (financially) to the relationship". This is what likely lead her to feel depressed, and the shift in her relationship with her husband:

> I never thought I was a person who identified myself as my fob, but I was I guess because I felt like nothing … so Bill and I had a lot of issues to work through. I didn't want to spend any money, I always felt money was power in your relationship, and he never made me feel that way but I felt badly that I wasn't contributing to the relationship because I wasn't working and I think my self-esteem got really bad. I felt so bad even just from being home all the time, you know. (Denise)

I wonder how Denise's situation postpartum may have been different had her working visa come through and she was able to work part-time as she always hoped she could do? From here, the relationship changes and is most challenged at this point in the *Losing*

Herself stage. The couple are living separate lives and the significant other may feel like they are 'in the doghouse':

> I don't think that my relationship with Bill was very good at the time because ... her didn't know what was going on with me for several months.... The relationship deteriorated. (Denise)

It was during this time that Bill decided to buy his motorcycle but it was $3,000 more than the couple intended to spend. Before, they had set aside this $3,000 for her school tuition, and now it was gone. After Bill drove the new motorcycle off the lot and home, Denise commented:

> I felt like I wasn't in the relationship; I wasn't important.... It took awhile to even be able to talk about it. And I just felt completely undermined as a person. I felt like just this woman who happens to live in the house and takes care of the kids, and I felt like that was all that I was to him. And so we really struggled in our relationship.... And I think another issue was that he didn't know how to be supportive of me.... Like I was even questioning whether he actually loves me, you know, like I just felt that was the end of our marriage.... Not from that one instance but just lots of things like that, where, he was making all these decisions and wasn't talking to me about them, and so I felt like, emotionally I started not to believe in marriage because I didn't think there was a partnership there.... But the hopelessness, to live without hope is like a wall came down, you know. And I had this feeling because of the relationship with Bill, I had this feeling that I could not accept a change. Like I was just stuck, and that was it. (Denise)

For Rene, she discovered that her "husband didn't know how to handle it (PPD)" and this left strain on their relationship:

> He [husband] disappeared into the background and just tried to stay away. He was afraid I'd bite his head off or something.... And the relationship with my husband was very, I just kind of I think that was the beginning of kind of pulling us apart.... Because he just didn't know how to handle it. (Rene)

In the last example of the *relationship with significant other* in the *Losing Herself* stage, Andrea's husband was getting into a pattern of doing his own thing:

> Paul just sort of went off with his dad and they were doing projects around the house... and working on the computer.
>
> (M: So how is it now for you?) Andrea: still pretty alone. My relationship with Paul is strained. There's anger on my part.... He needs to get it together too. There's a lot of things that he had years to work on, but he didn't. And I just I don't have the patience and the time to deal with the crap anymore. Not from his parents, not from him. You know, it kind of gets down to the wire. (Andrea)

One can just perceive the anger in Andrea's voice and she tells her side of the story, and it is this anger that will help fuel her into UH and building more of a partnership type of relationship. This was the case for Teresa:

> I was really lucky, by husband really helped out at night and things like that.... had excellent support from my husband.

Denise also noticed the shift in her relationship as well:

> It's much better now... because he's learned how to help me.

From this point, as things begin to settle in the *Finding Herself* stage, the couple can begin to focus more energy and time in their relationship –they're now 'okay':

> We started the babysitting swap with a neighbour across the street, and we're still doing that, so that's been about a year or so that we're doing that. (Denise).

As for the motorcycle incident, they eventually worked it out:

> Later on her confessed to me that he gone down to see it. I was upset that he hadn't said to me there's one that I like, it's more money, do you mind paying $3,000. Because we could have found a way, you know if he really wanted it.... And it wasn't even the money, it was the sense in the relationship. (Denise)

Denise and Bill were coming to a place where they were 'at home' with their interdependent relationship:

> Like the last things that I learned are talking to your partner, and saying what you need. I came from a background where you always waited for people to offer things to you.... And isn't that silly because, you know, like with Bill, how was he supposed to know what I need if I don't ask him for it? [Laugh]. (Denise)

In this last excerpt from Denise's transcript, you can hear all the reflection and wisdom of her words. There is laughter in her voice, and she is forgiving and accepting of Bill for who he is and understands what she needed to change to make the relationship work –all aspects of the *As Herself* stage.

To conclude, this framework, *Becoming Herself Through Postpartum Depression*, has foundational challenges and triggers that predispose a postpartum mother to enter into the stages of recovery through depression. These stages are met with emotional precursors that influence where she is in her process. These five stages *(Herself for*

Others, Losing Herself, Uncovering Herself, Finding Herself, As Herself) were defined and consisted of five key elements. The five elements were: *language, voice, perception, locus of control*, and *relationship with significant other*. Within the *Losing Herself* and *Uncovering Herself* stages of *locus of control* there were other key factors (universally experienced feelings and strategies) that were part of the mother's experience and related to her internal *locus of control*. The key variables that influenced movement from the *Losing Herself* stage to the *Uncovering Herself* stage were the mother's ability to be reflective and intuitive, and also any outside resources. This framework may possibly explain the discrepancies for why some women experience PPD and others do not. It may also explain why some women live with PPD for years and with varying degrees of severity.

IV. CONCLUSIONS & DISCUSSION

Finding Herself

The purpose in this study was to determine the lived experience of PPD and what helps mothers at this time. My goal was to expand current information and knowledge available in the area of PPD, and to share women's experiences of living with PPD so that the commonalities of the experience could be noted and the stigma lessened and hopefully removed. Since little empirical knowledge exists on the lived experience of PPD a hermeneutic phenomenological approach was employed to answer the research question. The findings indicated that the lived experience of PPD seems to parallel that of women's identity development. The length and severity of her PPD seem reliant on where she is in her process of identity development. These findings correlate with classical works on women's identity development, from the field of developmental psychology, by Ruthellen Josselson (1987, 1992, 1996), Daniel Levinson (1996), and Belenky, Clinchy, Goldberger, and Tarule (1986).

The findings from this study suggest that women work through a process of finding themselves while living with PPD. To begin, there are *foundational challenges (childhood stories, experiences of loss, history of depressive episodes, mothering, birth experience)*, together with *triggers (colicky/clingy baby, major life changes, grave financial concerns, having an older child)*, that predispose a mother to feel depressed postpartum. This predisposition is met with *emotional precursors (Fear/Guilt, Hopelessness, Anger, Acceptance, Peace/Wisdom)* which place a woman more at risk for PPD, but also the opportunity to work through earlier life challenges and to redefine who she is today as a result of these challenges and what she has learned through living with

PPD. This process is captured in the framework *Becoming Herself Through Postpartum Depression.* Initially, women work from a place of being 'herself for others' to 'losing herself' during the pit of the depression, to coming out of this deep depression as she 'uncovers herself,' and becoming settled in a place where she has 'found herself.' For some women, they may reach a place of contentment and peace with earlier life challenges, and discover that they no longer live with fear should they become depressed again in the future since they are content 'as themselves.' The conclusions to the experiences of the four women who participated in this study follows with their thoughts about what they learned from having lived with PPD.

Andrea

Andrea continues to work through her PPD, and has recently started back on her antidepressant medication. Andrea continues to recover from PPD; therefore, she is living with the *Uncovering Herself* stage of *Becoming Herself Through PPD.*

Andrea and her husband, Paul, continue to work on their relationship; however, now, there is more open communication and she is beginning to find more time to do the activities she enjoys –horseback riding and writing a romance novel. Andrea feels like she has more control over her situation compared to two years ago. There is still some remorse and anger in her language. In addition, there is energy in her voice and this is what will help her to move through to the *Finding* Herself stage in her recovery from PPD. Finally, Andrea has learned from her experience and would like to share what she has learned with other mothers:

> I definitely learned a lot around that (boundaries), my personal limits, that I have a right to them… I deserve to be nurtured, and I deserve to be loved, and I deserve

to be protected, and that's just that. You know, none of this I'm not good enough for those things.... Life's too short to mess around. Don't put up with the shit from the beginning. Just don't do it.... But yeah, to, to speak up for those things that I need or that I want. Yeah, it certainly taught me that.

Rene

Rene has worked through her PPD, and as a result has reached the *Finding Herself* stage of *Becoming Herself Through PPD* after two years. Rene and Steven are both content in their marriage, and feel "okay" with where they have come from and where they are headed in their relationship. As a result of her PPD experience, Rene feels stronger, and willing to help other mothers like her. Rene became a facilitator for the 'Mom and Tots' group in her parish community. This is the same group that helped her so much in her recovery, and the group she looked so forward to every Wednesday. Although Rene's turn at being a facilitator of this group is now over, she continues to meet with this group, and still looks forward to her Wednesday mornings each week. Rene has been off any medication for about a year now. Her language is more positive and reflective, and she sounds calm as she reflects back on her experience. In addition, the difference between the *Finding Herself* and *As Herself* stages can be noted:

> In hindsight, ... you know, I made it through, it wasn't so bad, but it was like still, I don't think I'd want to do it again. It was like thank goodness we always said we'd just have two kids. [Laugh]. So I didn't have to worry about my husband going oh, let's have another one. It's like no. Not unless you want to visit me and the kid in the looney bin... Yeah, it's like just, just going through all of that again, it's like no. I couldn't do that again. Forget it.

Teresa

Nearly three years later, Teresa is living in between the *Uncovering Herself* and *Finding Herself* stages. Although she and her husband Mark have always enjoyed a secure and supportive relationship, she still has some bad days and alternates between being calm and reflective to being frightened:

> And I think I'm ready to do that (wean counselling), and we [she and psychiatrist] were discussing. I'm kind of scared but we were talking about it and, and she said well what would you do, because I'm afraid of having a relapse and I'm afraid of going back into that dark space… and I think I always will be. And, and I said well, I'd go to my doctor or, you know, and she said but, so anyway it worked out. I know there is help out there because I got it for myself this time.

Teresa continues to be on her antidepressant medication, but is trying to wean herself off of it. However, an interesting point to note about Teresa is that she was different from the other three participants. Despite having an abundance of outside resources, a supportive husband, and strong female mentors throughout her pregnancy, birth, and postpartum experience, Teresa continues to work through her PPD. Could her medication be causing more harm than good? Could it be that the medication is keeping her from working on earlier foundational challenges such as her childhood stories, or the stigma attached with taking antidepressants? In the end, Teresa feels she has learned as a result of her experience:

> Like, the PPD was really, it was hard, it was hell, but I've grown as a person because of it. It's made me face a lot of issues in my life, and past abuses… but I still think back to some of those things now and they hurt still.

Denise

Denise fully recovered from PPD and as a result reached the *As Herself* stage of *Becoming Herself Through PPD.*. Her new baby daughter was 10 months old when she discovered that she was pregnant with her third daughter, and was in the process of *Finding Herself*:

> And, you know, I have to tell you that I cried when I found out that I was pregnant with [third child] because I was sure, you know, [new baby] was born in May of '99, and we got pregnant in March of 2000. So I was sure that I was, I was so worried about the depression coming back, and, you know, what if my life became that blur again… that's not life [laugh]. I didn't want to go back to the depression, I really didn't and I cried when I found out that I was pregnant.

However, about two month after her third child, a baby girl, was born, Denise stated that she was not fearful should she become pregnant again and experience PPD. She had also been weaning herself off of her antidepressant medication for months and was presently free of all medication for six weeks at the time of our meeting.

Soon after her third child was three months old, Denise and Bill and their three children moved to the mid-eastern United States where Denise was from. Denise returned to her full-time teaching position, and her husband ended his paid employment in the Forestry Ministry, which was ending in Victoria, and became the 'at home' dad. The couple was looking forward to the change and a fresh start. For Denise, the big lesson for her as a result of her PPD experience was communication:

> Like the last things that I learned are talking to your partner, and saying what you need. (Denise)

DISCUSSION

The purpose in the remainder of this chapter is to discuss the study in relation to: the efficacy of the method for data collection and analysis, commonalities in the findings between this study and relevant research literature, and findings that were unique and significant.

Discussion of Research Method

The use of a hermeneutic phenomenological approach fostered the emergence of the lived experience of PPD, and what helps a woman at this time. This design was most appropriate for the research question and the phenomena being studied. By employing this design, eight major themes emerged from the data and lead to the development of a framework –*Becoming Herself Through Postpartum Depression*. The framework helped describe the parallel process between recovery from PPD and the mother's identity development. Although each woman and her family perceived their experience as unique, common themes were unmasked and revealed.

Having a purposeful sample resulted in an adequate and appropriate sample of the lived experience of PPD. The sample seemed to develop steadily by word-of-mouth from the social worker at the University of Victoria Family Health Centre, from a facilitator at a nearby 'Mom and Tots' group in the neighbourhood, and through the information sheet that was made available at both of these sites. Potential volunteers who would be interested in contacting the researcher for more information could do so independently. As a result, most of the participants heard about the study through the social worker or facilitator who then suggested they contact the researcher at the given number for more information. Each of the women who volunteered for the study was able to contact the

researcher on their first attempt without having to leave a message on an answering machine. This simple fact seemed to make the difference. One woman, who was interested in obtaining more information about the study, got an answering machine on her first attempt to call the researcher. As soon as the message was retrieved and immediately followed up by the researcher, a message was left for the potential participant but the call was not returned.

After analyzing the characteristics of the women, variations were noted; however, the women were quite homogeneous in so far as these characteristics: marital status, cultural background, and giving birth to healthy, full-term baby girls. The women differed in their ages, degree of support postpartum, level of education, and socioeconomic status. All the women were similar with respect to three important characteristics: they were all highly motivated, articulate, and relatively well-informed about PPD.

Before beginning the face to face taped-recorded conversations, the researcher and participant engaged in a casual conversation about pregnancy, births, and child-raising experiences. Stories of childbirth and raising children were often exchanged and this seemed to make the meeting more conducive to sharing private feelings and thoughts towards her postpartum experience. This casual introduction usually lasted between 10-20 minutes and facilitated a collection of thick and rich data during taped conversations. The introduction also allowed for the open-ended structure of the conversation to be relatively focused on the postpartum experience since we had already shared other parts of her story that were not necessarily associated with the lived experience of PPD, and what helped her at this time. Following the conversation, the participant often told the

researcher that she was pleased to tell her story to someone who was interested in listening and who also lived with PPD.

Confidentiality of participation and of the taped conversations and transcripts were carefully maintained throughout the research process. No known breech of confidentiality occurred during the study.

Discussion of Findings

This part of the chapter will highlight findings that were common to what was reported in the literature, followed by findings that were less common and considered unique to this study. To begin, a description of how PPD is presently portrayed in the literature, including a discussion of the *universally experienced feelings* and *strategies* that were from this study and are commonly reported, will be given. Unique *strategies*, from this study, will be discussed next. Finally, a unique discovery from this study, the framework *Becoming Herself Through Postpartum Depression,* will be related to the classical works on women's identity development in the field of developmental psychology.

A Description of PPD

Postpartum depression is more than a depressed mood. It can last for a year or longer and women definitely feel disabled by the experience (Kendall-Tackett & Kantor, 1993; Pacific Post Partum Support Society [PPPSS], 1997). PPD is described as "tearfulness, despondency, feelings of inadequacy and inability to cope" (Pitt, 1968, p. 1325). It is also characterized by feelings of anxiety, loneliness, helplessness, hopelessness, emotional lability, and a decreased interest in sex. The onset is usually at two weeks postpartum and is often resolved by eight weeks postpartum (Affonso et al.,

1993; Lepper et al., 1994; PPPSS, 1997). However, these feelings can occur as late as six months postpartum and will reoccur up to two years postpartum if the woman is physically, mentally, or spiritually drawn from any experience, for instance a flare up from proctitis or ulcerative colitis, which may at the time seem unrelated to her previous birth experience (Dr. J. Papp, personal communications, April 15, 1994). Misri and Duke (1995) concur: "Depression tends to be a recurrent illness. Forty percent of women who have a first episode post-partum will have episodes unrelated to childbearing" (p. 662). The chance of PPD reoccurring with subsequent pregnancies is between 30-50% if the woman's experience of PPD had psychotic features (American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders-IV* [DSM],1994). Factors which influence the chance of PPD reoccurring are enhanced if the woman has a personal or family history of depression, marital problems, or excessive mood swings (Watson, Elliott, Rugg, & Biough, cited in Misri & Duke, 1995).

Even if a woman's risk for PPD reoccurring are relatively low given what we know, any woman who has ever experienced PPD lives with the horror that the 'nightmare' may come back to haunt her while she is experiencing the typical 'blues' until such time she intuitively knows that she is 'free'. An example, from the researcher's journal, of what it is like to live in this time of uncertainty follows:

> April 14, 1996: I don't know where the day has gone. It was about 6pm and it hit again. I'm feeling very down and I can't hold back the tears.... I'm afraid that my depression may come back. I tell Peter that my rational side of my brain says it's different because I had a positive birth experience, I am physically and emotional

> good, I have support, and it should just be the 'blues' but still I am afraid. Maybe I'm supposed to be experiencing these fears so that I can pass this period and tell other women who have had PPD and are experiencing the 'blues' that it will go away and it's natural to feel fear about PPD coming back.... I hadn't been out all day so this didn't help me too much. I must admit that just smelling the air made a difference. It's still there but it's starting to lift.

To summarize, discussion of the signs and symptoms of PPD, are prevalent throughout the literature. The most commonly reported feelings associated with PPD were: exhaustion, anxiety, tearfulness, irritability or anger, decreased energy, appetite disturbances, feelings of inadequacy, guilt, helplessness, hopelessness, a depressed mood, an inability to cope, a decreased interest in sex, isolation, diminished cognitive abilities, recurrent scary thoughts of escape and suicide (Affonso, Mayberry, Lovett, Paul, Johnson, & Nussbaum, 1993; Lepper, DiMatteo, & Tinsley, 1994; PPPSS, 1997; O'Hara, Zekoski, & Phillips et al., 1990; Pitt, 1968; Sebastian, 1998; Stuart, 1999).

Universally Experienced Feelings

The terminology to express what it was like to live with PPD was changed, in this thesis, to universally experienced feelings from the traditional terminology of signs and symptoms of PPD. This latter terminology seemed too bio-medical. With having a bio-medical perspective on a woman's experience, there is the danger of limiting opportunities for recovery to only traditional ways of perceiving and treating PPD –such as with the prescription of pharmaceuticals and electroconvulsive therapy (ECT):

> During the postpartum period, rapidity of response to pharmacological treatment may be an urgent concern.... For example, an 8-week-old infant, whose mother

> has had PPD for a month, has been cared for by a depressed mother for half of his or her life. The patient's other children may also be affected by the crisis of maternal psychiatric illness at what is often a difficult emotional time for children even under optimal conditions.... For a selected group of patients, the use of ECT may be preferable when urgency of clinical response is key. (Raskin, 1999, p. 180)
>
> ECT is a highly effective treatment for mood disorders in the postpartum period.... In theory, ECT may be a first-line treatment for a breast-feeding patient, because the period of potential exposure to medication is circumscribed. Specific risks of ECT during the postpartum period are not known, but it is worth noting that transient forgetfulness may be compounded by the chronic sleep deprivation often present in new mothers. (pp. 188-189)

I was dismayed when I came across this suggested treatment for mothers who are feeling depressed postpartum. Will not the difficulties with interpersonal relationships and other factors associated with PPD still remain following ECT treatment? Will the mother's self-esteem be improved or damaged further as she comes out of her therapy? How might this experience affect her road to recovery from living with PPD and to finding herself? To date, no empirical research has been conducted on the effectiveness of ECT with PPD. To treat PPD as a medical illness seems to close off all other possibilities or hopes of achieving a more natural and empowering recovery.

Universally experienced feelings, specific to this study (exhaustion, crying, anger, decreased interested in sex, isolation and guilt; inability to process, retain, or concentrate on information; inability to cope, and feeling helpless, stressed and depressed; feeling

crazy, and having scary thoughts; hopelessness, and wanting to escape) will now be discussed.

Exhaustion

All of the women in this study felt exhausted from a lack of sleep. Although becoming exhausted is not too surprising when sleep is interrupted frequently and for an extended period of time with a *colicky/clingy baby*, what is surprising to note is that insomnia is apparently just as prevalent with PPD (PPPSS, 1997; Sebastian, 1998). This became the case for Denise. An example of how insomnia may develop is clearly portrayed in the following excerpt:

> Sleep deprivation and the broken sleep most women experience are major factors influencing energy levels and moods. Slowing down and relaxing enough to sleep can seem impossible. 'I would lie awake at night and all the things I had to do, or I should have done differently, would run through my head.' Many women cannot get to sleep at all. ' I was so tired but I couldn't sleep. I'd almost drop off, then something would snap in my head and that would set all my nerves jangling.'
>
> Other women find they can get to sleep initially but then wake up with frightening nightmares that leave them fearful of falling asleep. As the hours tick by, the woman may feel exhausted and overwhelmed at the thought of having to start a new day. (PPPSS, 1997, p. 11)

Emotional Lability –Crying and Anger

During PPD, a mother feels overwhelmed with emotion and sadness, and for some even numbness (PPPSS, 1997). This is a time when she may "burst into *tears* for no apparent reason, as if the tears come 'out of nowhere'" (p. 5). Each of the women in the

study had this experience while living in the *Losing Herself* stage. However, there were times when Teresa, for instance, was unable to cry: "Some women feel very sad all the time but cannot cry." Although Teresa would have preferred to "have a good cry," as she feels it would have made her feel better at that time, she was unable to due to a side effect of her antidepressant medication. This sensation of unending tearfulness, and in one case an inability to cry sometimes, leads both the mother and her family to feel confused and concerned. How is it that the mother is feeling sad and overwhelmed, instead of happy and joyful with the arrival of a new baby? The feelings of confusion and concern may turn into feelings of fear once the mother becomes irritable and *angry*.

While raising children, mothers may feel irritable and frustrated at times with their children. However, the intensity of these feelings may increase during a PPD:

> Many women talk about yelling at the older children, shaking the toddler, gritting their teeth, getting into screaming fights with their partners and generally being angry at themselves and the world. 'As my body and mind became more and more exhausted I could hardly stand my baby crying, and there were moments when this sound was so painful that I was sure that I was going to hurt him if he didn't stop.'
>
> In view of the sadness, confusion and helplessness that many women experience, this anger and frustration is an understandable response. Sometimes women say it feels as if their anger could turn into a monstrous rage and they become anxious and frightened. (PPPSS, 1997, p. 5)

These feelings of anger were felt by all of the women in this study at one time, however, the feeling of having the anger turn into a monstrous rage was experienced by only one of

the mothers (Teresa). Although it may feel like a step backwards, with respect to their recovery, this anger "is a good sign for it means that now they have the energy to feel their anger", and move into the *Uncovering Herself* stage.

Decreased Interest in Sex

Not surprisingly, a woman who is feeling depressed, exhausted, and at times angry with herself and the world has sex as the last thing on her mind. The women at the postpartum support society in Vancouver, BC, would concur (PPPSS, 1997). This was certainly the case for the women in this study. However, it is interesting to note Rene's understanding for her lack of libido. For Rene, she felt that the antidepressant that she was taking at the time was the reason for her decreased interest in sex, and for this reason, it was the impetus to finally stop taking her medication all together. A lack of libido can lead to feelings of guilt and isolation –as was the case for Andrea, Rene, and Denise.

Isolation and Guilt

The women expressed a variety of reasons for feeling *isolated*: he (husband) always seemed to be busy with work and trying to avoid her (Rene); he just went back to his old life, and acted as if it was business as usual (Andrea); physically, I was not capable of leaving the house, and even if I was I didn't have or didn't know how to drive our car (Andrea and Teresa); I was stuck at home all day with the kids instead of me being the one who could go to work (Denise). For me, I felt like I was alone with my feelings and that no one had felt like before –at least I knew of no one who had had PPD.

These feelings of isolation are common with PPD, and can be validated at times when other mothers, who are not living with PPD, get together in community groups or at the local playground:

> Seeing other mothers chatting at the playground (or at Baby Talk groups at the local community centre) can be devastating for a depressed mother who feels incapable of joining in and wonders what's wrong with her. It seems as if she is the only one in the world who feels this way. (PPPSS, 1997, p. 9)

During PPD, a mother may experience *guilt* for having thoughts of harming their new baby (Teresa), or for having emotionally abused their other older child (Rene and Denise). In addition, she may "think that it is her fault she's doing so badly and causing so many problems for the family." This was the case for me as I was going through PPD. However, it should be noted that the most intense guilt is "experienced around the baby and the older children":

> With all that is written about the importance of the first five years of a child's life, early bonding between the mother and child, and the effect of a stressful environment on children, most women are devastated by thoughts about the harm their depression might be doing. Often a vicious cycle develops. Out of guilt about her depression, a mother may force herself to try and do more for her children than she's capable of. As a result; the woman's resentment and guilt increase, this makes her feel more depressed than ever. (PPPSS, 1997, p. 10)

Cognitively Challenged

In this study, two women (Denise and Andrea) commented that they had difficulty processing, retaining, or concentrating on information. Although Sebastian

(1998) has noticed her PPD clients reporting a "diminished ability to think and concentrate, or indecisiveness, nearly every day" (p. 47) in her practice, and the same has been documented in another site (PPPSS, 1997), no empirical research on the same is available to date.

Inability to Cope and Feeling Helpless, Stressed and Depressed

Difficulties with adjusting to motherhood are understandable once the mother returns home with the new infant. This adjustment, as well as other life stresses, are risk factors which lead to PPD (Swendsen & Mazure, 2000). The stress that is involved with caring for a new infant is understandable. This is a time of discovery and transition. The parent(s) are discovering their infant's different cues and adjusting to a radically different life schedule. This is also a time of transition for two reasons: the woman's body is in a period of adjustment once again, and her sense of identity is in a period of revision. Who am I now, and what does it mean to be a mother? Although there is a physical separation of the infant from the mother's womb at birth, there is an ever-present awareness for the infant who has just been born. Therefore, the stress of adjusting and caring for the new infant, even if the infant was planned, is significant since one can never fully prepare for this experience. These difficulties may be partially related to the expectations imposed on mothers by mothers and from society in general.

Cultural myths within our society have a strong influence on whether or not women develop PPD. "Society, to a large extent, has great difficulty in accepting that unhappiness and sustained misery can be characteristic of this time and not the celebration which we might customarily expect" (Cox, 1989, p. 327). Difficulties remain because of a lack of knowledge amongst health care professionals and society as a whole.

Perhaps "one of the most damaging assumptions (made by society) is that women are biologically equipped to bear children ... and have instinctive knowledge of how to mother" (Jebali, 1993, p. 59). The problem with this assumption is that women are bound to feel inadequate if they lack this belief or inherent knowledge and may not agree that motherhood is a fundamental part of a woman's life. For example, would it not be wonderful if the newborn came with instructions! Even if the woman supports society with this assumption, society is being hypocritical since motherhood is idealized but in actual fact it is "trivialized and undervalued" (p. 59). As a result, researchers (Stewart & Jambunathan, 1996; Ugarriza, 1992) have suggested that PPD is a 'culture-bound syndrome' that develops since there is a lack of supportive rites and rituals surrounding childbirth in our society. Therefore, difficulties with adjusting to motherhood are certainly warranted.

Feeling Crazy and Having Scary Thoughts

Both Rene and Teresa felt like they were "going crazy" when they had scary thoughts. Rene's thoughts would be about her having a heart attack and the kids being left all day, alone, with no one to help them until her husband return home late that night. Teresa's thoughts were about "being carted away" once the authorities discovered "how truly crazy she was." For me, I would hallucinate, and have painful memories come-out of-the-blue:

> It is very common for women who are experience PPD to have frightening fantasies. The fantasies can be thoughts, visual images, sounds, or voices.... Sometimes the woman is haunted by painful memories. These memories are

described by the mother as 'coming out of the blue' and 'having a life of their own.'

> When women experiencing PPD have scary thoughts, they usually feel as if they are going crazy. This is not the case. These fantasies are commonly experienced when a woman is going through a PPD. (PPPSS, 1997, p. 14)

These memories and frightening fantasies may be considered some of the *foundational challenges* that the mother needs to work through for a full recovery from PPD.

Hopelessness, Escape, and Suicidal Ideation

None of the women reported having suicidal ideation, however, a feeling of hopelessness, and wanting to escape was prevalent in all. Only Teresa voiced that she had said to her psychiatrist that she had thoughts of committing suicide, but she "knew she never would." Interestingly, there is no available literature on the sensation of wanting to escape. However, women experiencing PPD frequently have recurrent thoughts about committing suicide (Sebastian, 1998), and therefore, it will be discussed.

Fortunately, the incidence of committing suicide while depressed postpartum is rare. However, the two exceptions to this are adolescent girls, since their risk is already significantly elevated, and women who give birth to stillborn babies. For these two groups of women, if suicide occurs it will likely be within the first month postpartum, and in a violent way (Appleby, 1991). Lower than average (<4.78 mmol/l) serum cholesterol concentrations have been associated with increased rates of suicide (Zureik, Courbon, & Ducimetiere, 1996) and postpartum depression (Luckas, Buckett, Aird, Kingsland, 1997; Ploeckinger, Dantendorfer, Ulm, Baischer, Derfler, Musalek, & Dadak, 1996) in the population. Zureik et al. conducted a study, from the National Institute of

Health and Medical Research in Paris, involving 6,393 men over a 22-year period. Annual serum cholesterol levels were taken for four years consecutively with a follow-up 17 years later. At the time of the follow-up, the authors discovered that 32 of the 6,393 men committed suicide. The deceased men had serum cholesterol concentration that decreased by more than 0.13 mmol/l a year; whereas, the surviving men had serum cholesterol concentrations that remained stable and within the average (4.78-6.21 mmol/l) over the years. As a result, the authors concluded that men with lower than average serum cholesterol levels were three times more likely to commit suicide then men with average serum cholesterol levels (Zureik et al., 1996). This study has important implications for women suffering from PPD since suicidal ideation is a commonly expressed in women who live with PPD.

In a second study conducted at the University of Vienna, serum cholesterol levels were taken during pregnancy and then at birth from 20 women. The researchers discovered that women were more likely to be depressed after delivery if their serum cholesterol levels dropped sharply after birth (Ploeckinger et al., 1996). Luckas et al. (1997) concurred. As a consequence, it appears that markedly low serum cholesterol levels, discovered from a blood test taken immediately postpartum, may be one way of detecting if a women is at an increased risk for experiencing PPD.

To summarize, the *universally experienced feelings* (exhaustion, crying, anger, decreased interested in sex, isolation and guilt; inability to process, retain, or concentrate on information; inability to cope, and feeling helpless, stressed and depressed; feeling crazy, and having scary thoughts; hopelessness, and wanting to escape) that were

prevalent in this study were considered. To date, no known empirical research exists on the universally experienced feelings associated with PPD.

Variables to Bridge from the Losing Herself to Uncovering Herself Stage

Having reflective and intuitive abilities, and/or outside resources, assists the mother to move through her depression towards recovery. This was a unique finding in this study; however, the variable of outside resources has been noted to be effective. An outside resource was considered to be either a person who has knowledge or expertise in PPD (physician, obstetrician, community health nurse, doula, counsellor, psychiatrist) or a person or agency who can be hired to help (masseuse, chiropractor, cleaner, chef, diaper service agency, organic grocery drop-off service, gardener, nanny).

In this study, one of the mothers, Teresa, had a doula supporting her throughout her labour and early postpartum period. Having a doula was "great" for Teresa and seemed to make all the difference for her. I wonder how her recovery from PPD may have shifted if this outside resource was not available to her? Did having a doula impede her recovery as she did not need to rely on her own inner resources at this time?

Wolman, Chalmers, Hofmeyr, & Nikodem (1993) conducted a study on the affect that clinically oriented care has on the woman during labour. Women volunteers were asked to participate in the study as labour supporters. Findings from their study suggested that "the clinical environment of modern birth may have adverse effects on physiologic or psychologic outcomes" (p. 1389). Consequently, a labour supporter ameliorated the negative impact that the unfamiliar clinical environment had on the woman's birth experience. Many authors (Anderson, 1996; Hedstrom & Newton, 1986; Hodnett &

Osborn, 1989; Hodnett, 1995; Hofmeyr, Nikodem, Wolman, Chalmers, & Kramer, 1991; Larimore, 1995; Thorton & Lilford, 1994) would concur.

Teresa also had a "very supportive" obstetrician who was "just amazing," and a psychiatrist and Member of Parliament who were also "very supportive" and facilitated her husband's return home from his posting in the navy. In addition, Teresa, as well as the other four women –namely Rene, Andrea, and Denise, each received counselling and found this instrumental in their recovery from PPD, and will be discussed further within the *strategies* discussion.

Key strategies (emotional support, counselling, medication) have been proposed to assist with the management of PPD and will be discussed accordingly. In addition, other strategies that were unique to this study, and will also be provided were: time alone as a couple and for pursuing self-interests, goal setting, using aids (light-timer, template), and communicating with significant other.

Instrumental and Emotional Support

An important way to facilitate a woman's recovery is through instrumental and emotional support (Foyster, 1995; PPPSS, 1997; Wolman et al., 1993). Instrumental support includes receiving help with meals, doing the laundry, and completing household errands. The best kind of emotional support needs to be conveyed by the woman, but the difficulty is in communicating this information. This is a time when she would most need someone to be able to read her mind as asking for support is challenging. Once the woman accepts and feels this support she is better able to listen to her own needs. It is at this time that she is on the road to recovery.

According to O'Hara et al. (1990), women who are depressed postpartum report significant discrepancies between the support they would like to receive and the support they perceive they are receiving. Although the perceived lack of support is felt with both family and friends, the primary feeling of loss occurs with that of the husband. This was also the case with the women in this study.

Misri, S. Kostaras, Fox, and D. Kostaras (2000) conducted a survey to determine the impact of partner support in the treatment of mothers suffering from PPD. Only mothers who met the DSM-IV criteria for major depressive disorder were included in the study. The mothers in this study ranged in age and were between 23-46 years old.

The mothers were randomly assigned to two treatment groups: the control group consisted of mothers only (n=13), while the second support group consisted of mothers and their partners (n=16). Both groups were seen for 7 psycho-educational visits each. The partners in the second group participated in 4 of the 7 visits. All participants were administered a set of questionnaires: Edinburgh Postnatal Depression Scale, Kellner Symptom Questionnaire, Dyadic Adjustment Scale (DAS), Parental Bonding Instrument, and the Mini International Neuropsychiatric Instrument.

The significance differences between both groups on baseline measurements, post-intervention measures, and follow-up assessments was determined using independent sample t-tests. All statistical analyses were performed at an alpha level of .05. There were no significant differences in terms of baseline assessment between the two groups. By visit 6, there was a profound margin and a statistically significant difference in scores between the two groups: The support group indicated a more positive appraisal of their relationships. In addition, the support group has significantly higher

overall DAS scores than did their counterparts in the control group at visits 1-6. The health of the control group partners was also significantly worse than that of the support group partners.

There was a zero attrition rate as all 29 participants attended all 7 visits and completed all assessments. Limitations to this study were: the sample size for both groups was small, most of the participants were white, and there was a short follow-up period. Considering this, Misri et al. (2000) concluded that partner support has a measurable effect on women experiencing PPD.

Counselling

Although antidepressant therapy is frequently a treatment option for women with PPD, "many women who choose to breastfeed their infants strongly desire to avoid taking medication. Furthermore, pharmacotherapy does not specifically address the interpersonal disruptions that occur during an episode of PPD. Consequently, effective psychological treatments for PPD are of paramount importance" (Stuart, 1999, pp. 144-145). Tracey (2000) concurs especially in terms of the bonding relationship between the mother and child.

Stuart (1999) and O'Hara, Stuart, Gorman, and Wenzel (2000) posit that interpersonal psychotherapy (IPT) alleviates the symptoms of depression. IPT is based on short-term work which focuses on the interpersonal disruptions that occur during episodes of depression: "IPT specifically targets patients' interpersonal relationships as a point of intervention and is designed to assist patients to modify either their relationships or their expectations about their relationships" (Stuart, p. 145). The remainder of this discussion will focus on individual, group and couple counselling strategies.

Individual Counselling. Individual counselling can facilitate a woman's journey with PPD. Deep, emotional issues may begin to be resolved that were previously unknown or brought to a level of awareness. In addition, issues surrounding self-esteem can be explored and enhanced with each session. Self-esteem has been shown to "mediate the effects of everyday stressors and the quality of primary intimate relationships on depressive symptoms" (Hall, Kotch, Browne, & Rayens, 1996, p. 231). Interestingly, one study explored the efficacy of both fluoxetine and cognitive-behavioural counselling, and discovered that combined together there was no advantage, but counselling alone was effective (Appleby, Warner, Whitton, Faragher, 1997). It is the writer's concern, however, that some women may be seeing an inappropriate practitioner who is perceived to be helpful by their title, but who lack the personal or experiential knowledge that would benefit women suffering from PPD specifically. In addition, the financial funds required for counselling, which has been of benefit, may become a concern for mothers and their family. Possible solutions to these problems may be achieved by joining a women's group in the community as will be addressed shortly.

Group Counselling. Group work is another key avenue for accessing emotional support, personal growth (Corey & Corey, 1997; Creedy, 1993; Eastwood, 1995; Gladding, 1995; May, 1995; Pitts, 1995; Wickberg & Hwang, 1996), and for debriefing the childbirthing and postpartum experiences. In addition, groups provide opportunities for women to manage conflicts about their identity, gain a sense of survival, and to develop a new perspective on their experience (Creedy & Shocet, 1996). Sharon Butala, a Canadian author, whose life changed significantly once she moved from the city to begin

a new life in the rural southwest corner of Saskatchewan, describes what it was like for her to be in a woman's group:

> We were exploring womanhood too, well beyond the stereotypes we'd been raised in: what it is to be female, to be wives and mothers, to approach the world as female beings. We were searching for and finding our power through deliberately trying to tear down the walls of fear society, we had believed, had forced us to erect between us. (1994, p. 31).

Interestingly, women with whom one may not expect to initiate a conversation with, for fear of having little in common, suddenly become like sisters since a common thread runs within. The stories may be different, but the themes are much the same.

Group work enables a woman to discover that she is not alone in her experience and that the themes of her experience are shared. To achieve this, relaxation exercises or meditations may be employed to facilitate a woman's journey through PPD. Gruen (1993) provides group psychotherapy weekly for her clients over a span of six months. During this time, the four most commonly expressed symptoms by women suffering from PPD (depressed feelings, anxiety, distress, and low self-esteem) are discussed with the intent of diminishing the intensity and eventual distress of these symptoms. Husbands or partners are involved from the start to provide their insights during the assessment sessions. Other additional benefits to meeting with other women with similar experiences are that answers to common questions, such as the ones addressed previously, can be explored.

Couple Counselling. With PPD, not only is the mother affected, but also her partner. All that was once known changes, and assistance with the role transitions can be

beneficial at this time. The goal for the marital therapist then would be to "foster the development of a secure bond between the partners" (Donovan, 1999, p. 23).

Apfel and Handel (1999) suggest that some of the benefits of couple therapy is that: 1) the couple can be given permission to grieve their old life, and to be nourished by their new family, or to vent feelings about how the baby has taken all attention away from each other; 2) there is a safe environment provided to clarify what this crisis has meant to each partner; 3) the couple may receive therapy to replace fantasy families with a real family; 4) the couple may re-estabish the trust and love in their relationship if it was tarnished during PPD; 5) there is an opportunity to develop creative solution to obstacles (see p. 169-177 for a fuller account). In addition to these suggested benefits and strategies for couple counselling, I would add that there is an opportunity to establish good communication between the couples, and an opportunity for learning to arise when the other's perspective and wishes are discovered.

Ruthellen Josselson (1992) suggests that in her work with couples, it is in the space between the partners, the environment they create that links themselves to each other, that will become the foundation for their relationship. She conceptualizes eight dimensions which may be used to describe the space between them: holding, attachment, passions, eye-to-eye validation, idealization and identification, mutuality and resonance, embeddedness, and tending. With PPD, these dimensions shift and settle within their pathological poles of absence or excess. For instance, in the dimension 'attachment', there is aloneness and loss (absence) and fearful clinging (excess).

Medication

Certain physiological changes appear to be associated with the symptoms women experience with PPD. The three most commonly cited physiological explanations for PPD are: hormonal imbalances, serotonin levels, and diminished levels of serum cholesterol concentrations. Consequently, this leads to the prescription of certain medications and therapies –namely hormone therapy, and the use of antidepressants. The other types of medication that is prescribed to women with PPD are antipsychotics (i.e., Haldol) and mood stabilizers (i.e., Lithium). Since the most favored explanation for why women experience PPD is related to "raging hormones," this issue will be discussed first; followed by, the other two reported factors –serotonin, and then cholesterol.

Hormone Therapy. Inarguably, the postpartum period is a time of tremendous change. In particular, substantive changes in hormonal levels are occurring in conjunction with the involution of the uterus, a reduction in blood volume, significant weight loss, and physical recovery from labour to name a few. However, if the woman gives birth to a healthy baby, for example, and then experiences some marked mood swings following the third day blues, some health care professionals and members of the woman's family or friends make the assumption that this discrepancy is the result of hormonal problems. Some authors (Dalton, 1985; Gregoire, Kumar, Everitt, Henderson & Studd, 1996) would also agree.

Dalton (1985) strongly supports this claim as evidenced by her prophylactically administering progesterone to 100 women who had previous episodes of PPD. Her findings were that only 10% of these women went on to experience PPD again, whereas a significantly higher number of women (68%) experienced PPD because they chose not

to take the progesterone prophylactically. Therefore, she concluded that a sudden drop in progesterone caused PPD. However, a double-blind design would have enhanced these findings. In addition, it is difficult to assess whether these test results were related to progesterone therapy or a placebo effect.

Gregoire et al. (1996) investigated the efficacy of administering transdermal estrogen for women with severe PPD. They utilized a double-blind placebo-controlled design involving 61 women. The women's level of depression was assessed by administering the Edinburgh Postnatal Depression Scale (EPDS), and then the efficacy of the treatment was determined. The authors found that the women "improved rapidly" after a month of treatment, "and to a significantly greater extent than controls" (p. 930). Therefore, they concluded that transdermal estrogen was an effective treatment for PPD. The writer would like to comment that confounding variables (counselling, group work, receiving emotional and or instrumental support) may have contributed to the success rate of the treatment; however, these other variables were not addressed. Although a few authors contend that hormonal therapy is a viable treatment for women with PPD, many more authors (Barclay & Lloyd, 1994; Butler & Leonard, 1986; Harris, Lovett, Smith, read, Walker, & Newcombe, 1996; Jermain, 1992; O'Hara, Schlechte, Lewis, & Varner, 1991; Susman, 1996; VanderMeer, Loendersloot & VanLoenen, 1984; Wisner & Stowe, 1997) would disagree.

Harris et al. (1996) conducted a prospective study on 120 primiparous women who were free from any major marital, financial, or health problems. The saliva of these women was collected twice daily, from 38 weeks gestation until the baby was 35 days old, for cortisol and progesterone profiles. Seven of the 120 women developed PPD with

no associations between progesterone and mood at the end of the study. The authors concluded by providing no support for the prophylactic administration of progesterone following birth.

Finally, Butler and Leonard (1986) conducted a study on the efficacy of an antidepressant (nomifensine) treatment, an selective serotonin re-uptake inhibitors (SSRI), for women experiencing PPD. Pre and post-treatment levels of estradiol and progesterone were taken from 16 participants (eight had PPD and eight were nondepressed controls). Interestingly, the authors found no difference in the pre and post levels of all 16 participants even though the nomifensine alleviated the symptoms. The authors concluded that the serotonin levels, rather than the hormonal levels, were related to the symptoms of PPD being alleviated in their participants.

Antidepressants. Serotonin is a neurotransmitter that is released by blood platelet cells to facilitate vasoconstriction of the blood vessels (Hole, 1984). Apart from serotonin's function to control bleeding, no known research exists on how it may alleviate some of the symptoms associated with PPD specifically. However, medications known as SSRIs [fluoxetine (Prozac), paroxetine (Paxil), seratraline (Zoloft)] are commonly prescribed for women suffering from PPD. SSRIs are attributed to producing elevated mood states, relaxation, limiting non-productive behaviour and thought patterns, sleep regulation, and appetite control. In sum, SSRIs increase the availability of serotonin, by blocking its reabsorption in the body, in order for a person to achieve a higher sense of well-being, relaxation, and elevation in their mood; however, research is critically needed to assess the efficacy of SSRIs in treating women with PPD and

producing the aforementioned results. According to Sebastian (1998), women suffering a first time episode of PPD respond more quickly, within four weeks, to SSRI.

Denise and Andrea did not experience any side effects from taking their SSRIs. Teresa, on the other hand, was unable to fall asleep. Once she did get to sleep, she did not have a restful sleep. This lead to an additional medication to help her get to sleep, and then one to assist her in achieving a restful sleep. For Rene, she experienced insomnia with one of the SSRIs, and then a second one reduced her libido that was already challenged. Following this, Rene decided to stop taking her medication, and this helped her "to return to normal."

Strategies that were Unique to this Study

Strategies that are not harmful to mothers who are breastfeeding and do not have any side effects were discovered by the women in this study. These were: finding time alone as a couple, setting time aside to pursue self-interests, goal setting, using aids such as a light-timer or template, and communicating with their partners.

Time Alone As a Couple and for Pursuing Self-Interests. Denise and Bill came up with the idea of a babysitting swap. They took turns going out with a family on their street. When it was Denise and Bill's turn to babysit, one of them would go over to watch the neighbour's kids while the other stayed home and watched their own children. The next time, Denise and Bill were able to go out and have a turn. They discovered that they were able to enjoy each other as a couple once again.

Rene was able to find time for herself at her Mom and Tots group in her parish community. Each week the group would meet and the grandmas in the community would volunteer their time to sit and play with the children while the moms had coffee and time

alone from the children in another room. This time each week seemed to help Rene move through her depression and into recovery.

Andrea managed to carve away time with a friend who was also a writer after her baby was eight months old. They planned time to go to a conference for the weekend up island. Although this time alone ended up being an upsetting time for Andrea because she felt unable to do what used to come so easily to her, she learned how much this ability meant to her, and it gave her the permission to take time away to pursue self-interests in order to help find herself and move through her PPD.

Goal Setting. The women found creative ways to make their days pass by, and to feel good about something they had accomplished. Denise would give herself small goals to do each day that would go towards her major goal that she wanted to accomplish. For instance, if her major goal was to clean the bathroom, then her small goal would be to clean the bathroom sink by the end of the day. She found goal setting made her daily household tasks manageable, and she felt like she had accomplished something at the end of the day. Often she felt like cleaning something else in the bathroom and did, but she knew she didn't have to, and this small strategy made all the difference to her day. This was an effective strategy for when she felt overwhelmed by the daily demands in her life.

Rene would plan to go shopping for dinner daily. Having the opportunity to be around other adults, who were interested in chatting to her because she had a new baby, was something that she looked forward to everyday. This was also something that got her out of the house, and lifted away her feelings of isolation and depression. Like Rene, Teresa would also go shopping daily; she would create an errand that needed to be picked

up everyday. Teresa gave me the example of going to London Drugs just to buy a bar of soap.

Using Aids. Denise's baby was born during the winter season. She found herself becoming more and more depressed as the days were getting shorter and the nights longer. Denise dreaded returning home with her children after an outing to her sister-in-law's or a friend's place in the afternoon, because it would already be dark by the time she returned home at 4 pm. Consequently, Denise came up with the ingenious idea of using a light-timer on her living room lamp. Now, every time she return home, she was "returning home to the ligh," and this simple strategy seemed to significantly affect her mood.

Denise's story reminded me of people who suffer from seasonal affective disorder (SAD). For people living with SAD, the use of phototherapy has been effective, and has recently been tried on women living with PPD (Corral, Kuan, & Kostaras, 2000; Sebastian, 1998).

The second unique strategy that Denise discovered was the use of a template for reading. She got the idea from her previous teaching experience with a grade one student. This student was unable to concentrate, retain, or process information so a template was created for him. Denise found that having a little window to look through on a square piece of cardboard made a significant difference in how she was able to sit and enjoy the newspaper. Without this template, she was reminded of her inabilities and became fearful of the daily newspaper as it reminder her of how she was "losing her mind."

Communicating with Partner. "Unfortunately marital distress often occurs hand in hand with other symptoms and problems, particularly … depression" (Donovan, 1999, p.

23). Donovan suggests using emotionally focused couple therapy (EFT) to counteract the marital distress. The two basic goals of EFT are: "exploration and reformulation of (the) emotional experience, and the restructuring of interactions" (p. 25).

Both Andrea and Denise stated that communication with their partner was something they learned, is of utmost importance if the marriage is to work.

To conclude, this part of the chapter highlighted findings that were common to what was reported in the literature, followed by findings that were less common and considered unique to this study. A description of how PPD is presently portrayed in the literature, including a discussion of the *universally experienced feelings* and *strategies* that were found in this study were given. A unique discovery, the framework *Becoming Herself Through Postpartum Depression*, will be discussed next.

Discussion of the Framework

To begin, aspects of the framework that were cited in the literature will be discussed first. Following this, the framework *Becoming Herself Through Postpartum Depression* will be considered with classical works on women's identity development, from the field of developmental psychology, by Ruthellen Josselson (1987, 1992, 1996), Daniel Levinson (1996), and Belenky, Clinchy, Goldberger, and Tarule (1986).

Foundational Challenges

Birth Experience. Today, women predominantly labour and deliver their babies in hospital. This means that women will be under the care and supervision of the obstetrical staff in the chosen institution. Once a labouring woman is admitted to the labour and delivery unit, she is introduced to the culture of this system which is technologically focused (Jordan, 1993). Although the aim of care may be family-focused, it soon

becomes clear that the obstetrical staff, and not the labouring woman, controls the birth experience. For example, the labouring woman is expected to remove her own clothes and replace them with a hospital gown. Also, certain interventions could be perceived as symbolic of releasing the woman's personal control over the birth experience. "The intravenous is the symbolic umbilical cord to the hospital. It makes a birthing woman appear to be dependent on the institution for her life, just as the baby in the womb depends on her for life" (Davis-Floyd, 1994, p. xii). In addition, to the 'hanging-up of her dignity' as she enters the hospital, she is at risk for a cascade of interventions during her labour and birth experience.

Loss, Mothering, and Childhood Stories. As Judith Viorst (1986) posits in her book, *Necessary Losses,* there is a vital bond between our losses and our gains, and we must "give up in order to grow" (p. 16). I am reminded of this theme as I recall some of the foundational challenges related to loss, mothering, birth, and childhood stories that Andrea, Rene, Teresa, and Denise experienced and were later confronting as they moved through their depression. Since losses are a part of life, I believe we must live through them and confront them before we can grow and have peace as a result of our losses.

Triggers

Colicky/Clingy Baby (CCB). A CCB is a factor that predisposes women to feel depressed postpartally. This is a factor that cannot be prepared for since the new infant brings his or her own unique personality and disposition to the parent(s). In particular, how 'easy', 'difficult', or 'slow-to-warm-up' the infant may be is of importance. Forty percent of infants will have 'easy' temperaments; ten percent will have 'difficult' temperaments, and 15% will have 'slow-to-warm-up' temperaments. The remaining 35%

exists somewhere within these three categories (Chess & Thomas, 1977). For the purpose of this paper, the 'difficult' infant is of most interest since they typically cry for long periods of time, are difficult to soothe, do not adapt easily to changes in their environment (new people or routines), lack a predictable schedule (for eating, sleeping, and eliminating), and are described as colicky by their mothers and significant others around them (Cutrona & Troutman, 1986). In fact, infants who characteristically exhibited excessive crying, and who lacked adaptability and predictability also had mothers who experienced PPD (Mayberry & Affonso, 1993).

Major Financial Concerns ($). Warner, Appleby, Whitton, and Faragher (1996) administered the EPDS to 2,375 women, six to eight weeks after the birth, and screened them for risk factors associated with elevated scores on the EPDS. The four variables that were found to be associated with an EPDS score greater than12 were an unplanned pregnancy, not breastfeeding, the mother's job not being available following her maternity leave, and or the father's unemployment. Although further research is needed to assess how reliable these findings are, interesting conclusions resulting from this study must not be overlooked.

Women's Identity Development and PPD

The purpose in this part of the chapter is to create a greater awareness of what a woman with postpartum depression (PPD) is working through. Also included are ideas from developmental psychology to help understand this phenomenon. It is my belief that utilizing ideas from developmental psychology will stimulate preventative work aimed at facilitating movement and a more rapid recovery from PPD for these women so that it is not so debilitating. To help explain why PPD may have developed for the women in this

study, the following classical works on women's identity development will be utilized: Ruthellen Josselson's (1987, 1996) theory of identity development, Daniel Levinson's (1996) theory of development and the significance of age, and finally, Belenky et al. (1986) work on women's ways of knowing and the development of self, voice, and mind.

Women who are becoming mothers are women in transition with respect to many aspects, but perhaps most significantly in transition with respect to their own sense of identity. Therefore, a need exists to explore how women develop their sense of identity and whether or not this could impact on their chance of experiencing PPD. The discussion will now turn to how women develop their sense of identity from Josselson's perspective.

Josselson's Theory of Identity Development

Ruthellen Josselson recognized that there was no research available in psychology which addressed normal development in women. In the early 1970s, knowledge about women's development was derived from studying female psychotherapy patients and then this information was then generalized to all women. The non-clinical literature, although interesting and wise, held writers' biases, personal observations or experiences of friends and colleagues. As a result, Josselson wanted to conduct her research utilizing a more holistic psychological portrait of women -- women who are not necessarily remarkable in anyway -- who are not disturbed, victimized, or uncommonly successful (Josselson, 1987, 1996).

Josselson's research was based primarily on what was known about how men develop their sense of identity. In particular, the work of Erik Erikson (1950, 1956, 1968) and James Marcia (1966, 1976). Erikson's stage of identity versus identity diffusion is

salient, but more importantly his work on identity crisis and womanhood and her inner space. Marcia's ego identity statuses, based on his dissertation research, was seminal to her work. Josselson utilized Marcia's identity status interview which explored views about occupation, religion, politics, and sexual standards/ values, and then grouped participants into one of four categories (foreclosures, identity achievements, moratoriums, identity diffusions) based on their responses. Also mentioned as influences were Donald Winnicott (1965)'s work on object relation theory (maturational processes and the facilitating environment), and Peter Blos (1967)'s work on the centrality of separation-individuation as a precursor for identity formation.

Josselson (1996) conducted a longitudinal study, over 22 years from 1971-1993, observing the metamorphosis of identity with college women as they aged from 21-43. She chose this group of women to study since they had been largely ignored and had 'no grounds for complaints' given their privilege. Josselson utilized ethnographic methods with 60 women, from four different colleges and universities. Of these 60 women, 48 were assigned to one of Marcia's ego identity status groups, and then followed at 12 and 22 years later as they aged from 21-43. Josselson changed the names of the categories at the time of her 22 year follow-up, since she found the 'new' names to be more descriptive rather than evaluative in nature, to *guardians, pathmakers, searchers,* and *drifters* (Josselson, 1996).

The *guardians* made identity commitments without any exploration, and chose to assume unquestioned childhood ascriptions. The *pathmakers* made identity commitments after a period of exploration. The *searchers* are in a period of crisis/ exploration while trying to find values and goals that suit them. Finally, the *drifters* have no identity

commitment and make no effort to explore or create an identity (Josselson, 1987, 1996). While working with these women, Josselson was interested in what has felt essential to them in their lives, and how the stake they claim in life has changed over time. Of particular interest in this thesis is the group of women identified as *guardians*. My feeling is that this was the case for each of the women in the study, as well as for myself:

> I was born and raised in Victoria. I was the second of four children, with two sisters and a younger brother, and was identified as the nurturing/ mothering one who would likely marry, have children, and remain at home very happily. My life was dominated by a need to feel loved and cared for by my parents, and other relatives. Although I felt this need, without exception, I believed that my family was very close and provided me with a sense of security. While in high school, I knew I wanted to become a nurse. I believed that even if I did not like nursing in the end at least I would be a better mother for it. Nearly a decade later, after my experience with PPD, I am more insightful, more self-aware, and a stronger woman because the reality of my world opened up.

Revision for me has been wrenching, but invisible to the casual eye. Although the external part of my identity did not change, my internal frame of reference changed greatly. I began to see imperfections in myself and in my family of origin which allowed me to eventually consider other options freely without the need of having to ascribe to a particular mold. My experience with PPD appeared to have triggered the awakening, but I believe that each of us, including the women in the study, will or have acted on our awakenings at different times. The fact that all of us were *guardians* may have left us at a

higher risk for developing PPD, however, we were also experiencing a period of developmental transition at the time of babies' births.

Levinson's Theory of Women's Adult Development

The women's ages, in this study, ranged between 27 and 40 at the time of their first birth and experience with PPD. Although they exhibited similar identity statuses, their age appears to have played a significant role in the timing of their identity crisis when PPD developed. According to Levinson (1996), this period of developmental transition is known as the 'Era of Early Adulthood' and extends from age 17-45, and will be the focus of the following discussion.

The era of early adulthood connotes the end of childhood and the beginning of adulthood. This is a time when relationships are modified and adult identities are initiated. It is also the era of "greatest energy and abundance, and of greatest contradiction and stress" (Levinson, 1996, p. 19). Given the women's age at the time of their PPD, they would fall within what Levinson has coined the 'Entry Life Structure for Early Adulthood' constituting age 22-28:

> The tasks now are to make some key choices (especially regarding love/marriage/family, occupation, separation from family of origin, and lifestyle) and to organize one's life as a young adult. The first life structure built in an era is necessarily provisional; it is an initial attempt to make a place for oneself in a new world and a new generation. (Levinson, 1996, p. 25)

Interestingly, the women did make key choices in terms of their relationships, career in one case, and lifestyle. Although chronologically the women 'fit' into this category, it is important to note that they were at the end of this 'life structure' and beginning to embark

on their next developmental step (see Figure 3). Levinson has identified this period as 'Age 30 Transition' (Levinson, 1996). This latter period of transition more aptly describes what two of the women (Teresa and Denise) were experiencing at the time of their PPD:

> Age 30 Transition (age 28-33) occurs in mid-era. It provides an opportunity to reappraise the Entry Life Structure, to do some further work on individuation (including undone work of earlier transitions), and to explore new possibilities out of which the next structure can be formed. It is a time of moderate to severe developmental difficulty for most women and men. (1996, p. 26).

For Andrea and Rene, Levinson would claim that they experienced their awakening during what he calls 'Mid-life Transition':

> Mid-life Transition (age 40-45) is a developmental bridge between early and middle adulthood and is part of both eras. We terminate the life structure of the thirties, come to terms with the end of "youth" as it existed in early adulthood, and try to create a new way of being young-and-old appropriate to middle adulthood. The work of mid-life individuation is an especially important task of this period; it forms the inner matrix out of which a modified self and life evolve over the rest of this era. (1996, p. 26)

This reminds me of when Andrea was stating how she believes it is more difficult for older moms having their first baby. Andrea was referring to the pressure she feels now that she has her new baby at home, but still has to return to work because she is unable to take the ideal 5 years off to raise her child. By the time she is 45, she feels that she would

Figure Caption

Figure 4-1. Levinson (1996)'s Developmental periods in the eras of early and middle adulthood.

LATE ADULT TRANSITION: 60-65

ERA OF LATE ADULTHOOD (60+)

Culminating Life Structure for Middle Adulthood 55-60

Age 50 Transition 50-55

Entry Life Structure for Middle Adulthood 45-50

MID - LIFE TRANSITION: 40-45

ERA OF MIDDLE ADULTHOOD (40-65)

Culminating Life Structure for Early Adulthood 33-40

Age 30 Transition 28-33

Entry Life Structure for Early Adulthood 22-28

EARLY ADULT TRANSITION: 17-22

ERA OF EARLY ADULTHOOD (17-45)

be unable to move back into the career force as she should be beginning to think about retirement soon at that age.

Women's Ways of Knowing and the Development of Self, Voice, and Mind

Belenky et al. (1986) posit that women's ways of knowing and their development of their self-concept are intertwined. They have discovered that there are five different perspectives from which women view reality and draw conclusions about truth, knowledge, and authority. These five different perspectives are: Silence, Received Knowledge, Subjective Knowledge, Procedural Knowledge, and Constructed Knowledge.

In the Silence perspective, the women in this study felt disconnected from their family of origin, found themselves obeying the wordless authorities, maintaining the woman's place, unable to conceive themselves as a woman separate from her role as wife and mother, and having the experience of being seen but not heard. This first perspective reminded me of what the women in the study were experiencing in the *Herself for Others* stage with respect to their language, voice, perspective, locus of control, and relationship with significant other. The *Herself for Others* stage is a time when they may be perceived by others as the model wife and or mother.

In the Received Knowledge perspective, the women in this study were listening to the voices of others as their way of knowing –listening to the words of her friends, family, and authorities. Women at the position of received knowledge have faith that if they listen carefully enough they will be able to do the right thing and will get along with others (Belenky et al. 1986). I believe that this is also a position where they are still in the *Herself for Others* stage.

In Subjective Knowledge, there are two positions: the inner voice and the quest for self. Belenky et al. (1986) write that in the inner voice realm, "she no longer adheres to a dualistic perspective on truth and knowing. She is no longer subject to the dictates and whims of external authorities and no longer agrees with what some people think is a simple matter of right and wrong" (p. 53). This perspective seems to parallel that of the *Losing Herself* stage. It is this questioning, this reflective and intuitive knowledge, that will eventually bridge her towards recovery and into the *Uncovering Herself* stage. She is in a place where she quests for herself. As one woman in Belenky et al. (1986)'s study announced: "Right now I'm busy being born" (p. 76).

The next perspective, Procedural Knowledge, also has two positions: the voice of reason and separate and connected knowing. In the voice of reason, "they have learned that truth is not immediately accessible, that you cannot 'just know'. Things are not always as they seem to be. Truth lies hidden beneath the surface and you must ferret it out" (Belenky et al., 1986, p. 94). This stage reminds me of what is occurring near the end of the *Losing Herself* stage and just as she is beginning the *Uncovering Herself* stage:

> To most women, the first steps on this journey do not feel like progress. The voice diminishes in volume; it lacks authority. These women lack even the derived authority of those who, have faith in received knowledge, can parrot their elders that they speak the truth.... The inner voice turns critical; it tells them their ideas may be stupid. Women at this position think before they speak; and, because their ideas must measure up to certain objective standards, they speak in measure tones. Often they do not speak at all. But this is not a passive silence; on the other side of this silence, reason is stirring. (p. 94-95)

This sounds much like Teresa while she was in the throws of living with her PPD. The second position, separate and connected knowing, is not referring to any relationship between the self and another person, but rather relationships between the self as knowers and the other, which may or may not be another person. In other words, "people who experience the self as predominately separate tend to espouse a morality based on impersonal procedures for establishing justice, while people who experience the self as predominantly connected tend to espouse a morality based on care" (Belenky et al., 1986) This separate way of knowing reminds me of how the relationship with significant other is manifested in the *Losing Herself* stage. Whereas, the connected knowing seems more like how the relationship with significant other is manifested in the *Uncovering Herself* stage. In this stage, the mothers in this study were considering their affect on others and had more of a partnership with their husbands.

In the final perspective, Constructive Knowledge, there is an integration of voices, and an integration of herself and her mind:

> These women are all articulate and reflective people. They noticed what was going on with others and cared about the lives of people about them. They were intensely self-conscious, in the best sense of the word –aware of their own thought, their judgment, their moods and desires. Each concerned herself with issues of inclusions and exclusion, separation and connection; each struggled to find a balance of extremes in her life. Each was ambitious and fighting to find her own voice –her own way of expressing what she knew and cared about. Each wanted her voices and actions to make a difference to other people and in the world. (Belenky et al., p. 133)

It is at this point that I believe the mothers in this study were well on their way to overcoming their depression. In the *Finding Herself* stage, she is reflective, calm, and more positive. She is also encouraging and forgiving of herself. Her sense of her internal locus of control is solid and her relationship with her husband is stronger –they are okay now.

In this chapter, the phenomenon of PPD was explored with respect to what is presently known about PPD in the literature with the universally experienced feelings and strategies that were uncovered in this study about the lived experience of PPD. To explain why PPD may have developed later for the women in this study, three theories from developmental psychology were considered: Josselson's theory of identity development in women with a focus on her *guardian* pathway; Levinson's theory of development and the significance of age and possible development of PPD, and Belenky et al.'s theory on women's ways of knowing and the development of self, voice, and mind.

Childbirth is inarguably one of the most significant life events for a woman. Accepting and coming to know the new role called motherhood is an inner journey for women (Bergum, 1989). For some women, adapting to this new role is difficult and distressing even if they wanted their child and looked forward to one day becoming a mother.

For generations, women who have experienced PPD have used the same words, expressions, and feelings to describe what it is like to live with PPD. The severity of the experience may differ slightly from one woman's story to the next, but overall, the same themes come through. For instance, I imagined that I would feel tired and a bit

disorganized initially, but still expected to feel good about myself, my baby, and the rest of my family. I never dreamed that one day I could be one of the many silent women who have experienced PPD.

Women who are experiencing PPD may need a guide for the journey. Before we can guide women through this process, we first need to take the pains necessary to understand the lived experience of PPD from their perspective. In other words, if there is any way to relieve the 'feeling that Linus gets when his blanket is in the dryer', then 'the pains' are well worth the journey, for all involved, for in the end a stronger, more beautiful human being will have evolved.

> When you come to the edge of all the light you know and are about to step off into the darkness of the unknown, faith is knowing one of two things will happen: There will be something solid to stand on or you will be taught how to fly.
>
> (an anonymously written quote shared by M. L. Reilly, personal communication, October 3, 1997)

V. IMPLICATIONS OF THE FINDINGS

Herself To Help Others

The results of this study seem to indicate that there is a parallel process occurring, while mothers are living with PPD, between recovery and their identity development. The personal growth and empowerment that women gain from their PPD experience must not be underestimated or discounted. Since living with PPD can be horrific and challenging, and the family and friends are affected as well, there is a need to increase awareness in order to demystify PPD. The isolation and silence that are a part of PPD needs to be exposed and de-stigmatized. Clearly, there are strong implications for counsellors, psychologists, and other health care providers with respect to research, education, and practice.

Implications for Research

This study was conducted to determine the lived experience of PPD –specifically, to gain an understanding of what it is like to live with PPD, and what helps women at this time. This study represents a starting place for further research since very little empirical literature exists on PPD, and many further suggestions for research were discovered while conducting this study.

During my conversation with Denise, she stated: "I think that it would have been different if they had been closer in age. If he was still napping and if he was… two years old instead of three years old when the baby was born, it makes a difference." After Denise's comment, I wondered about the connection between the age spread between children and the lived experience of PPD –how does this factor affect the intensity or duration of PPD?

Andrea questioned the connection between breastfeeding and PPD: "There's only one thing, the connection between breastfeeding and depression. I'm wondering if somehow there's greater rates of depression in breastfeeding mothers than there is in non-breastfeeding mothers?"

After having conversations with Rene and Denise, I wondered about the connection between having strong women role-models or mentors and the intensity or duration of PPD. This also relates to my curiosity about the influence culture has on the incidence of PPD. Do cultural rites and rituals, that may be passed down from generation-to-generation from strong women role-models and mentors reduce the incidence of PPD? I was curious about this phenomenon as the women in this study were all Caucasian, North Americans. In addition, the women were all married, had laboured and given birth in hospital, and had healthy full-term baby girls: Is there a correlation between being a single mother versus a mother who is partnered and the lived experience of PPD? How does the setting of a labour and birth experience influence a woman's lived experience with PPD? Finally, all the women I have had the opportunity to meet and have conversations with over the last 10 years have had baby girls when they had PPD –is there a connection here between mothers and daughters, or is this a coincidence? In the generation to follow, what are the chances of the 'baby girl' later experiencing PPD? And has the experience with having PPD with this baby girl affected the bonding relationship?

Implications for Education

Educational programs for counsellors, psychologists, and other health care providers should include information on the experiences of women who have PPD that extends further than a brochure. Until we, as professionals, can fully appreciate the lived

experience of PPD, and what seems to help women and their families at this time, women with PPD may continue to live in silence and isolation. We need time to appreciate what it means to live with PPD and to begin to acknowledge the connection between recovery from PPD and women's identity development. Learning about PPD in this way has the potential of changing or improving our current practices with women and their families living with PPD.

Implications for Practice

Today, women predominantly labour and birth in hospital settings, however, this is beginning to shift since midwifery was legalized. Therefore, it is imperative that professionals working directly with women at this time (physician, obstetrician, doula, midwife, obstetrical nurse) and later during the postpartum period (physician, obstetrician, doula, midwife, community health nurse, counsellor, social worker, group facilitator, psychologists, and psychiatrist) are cognizant of the parallel process that seems to be present between identity development and PPD, so that they can facilitate their client's road to recovery from PPD.

Both Andrea and Teresa wanted me to suggest to facilitators of prenatal classes and 'Baby Talk' groups the need to have realistic discussion encouraged, and postpartum experiences that are less than ideal shared so that women living with PPD are not oppressed further:

> I think they should come from real experience. People don't tell you that it's ... not that bad, and oh, you're up in a few days, and these types of things. I mean, I felt like a total failure the whole way through and none of this happened.... I don't think I was prepared for all the things that did go wrong... I had an ideal

view of what it was going to be like and what t should be like, and that's not what happened.

You get a little bookmark at the hospital that says if you're having feelings of blah-blah-blah to watch, but it's not really ingrained in your mind. It was in such a way that I thought maybe I would be carted off if I had it. .... I think there has to be like at the baby talks, have a few sessions of realistic postpartum... We were going to that group and pretending, and feeling that we had to. (Teresa)

For Andrea, she wanted me to remind facilitators about two things: 1) the importance of encouraging women in postpartum groups to talk about their relations with their partners, so that there was a safe place to be able to begin asking those "scary questions", and 2) to inform postpartum women, and their family and friends, about where they can go to access resources and further information:

(M: You also brought up an interesting idea ... about support. Asking those scary questions. Like when you're in a relationship and it's, it's just taking so much energy that you don't have, and just looking at that. And even with the thought of even questioning it when you never would before. That's scary.) Andrea: It is. And I think more attention needs to be put to that in prenatal classes, because the divorce rate after a child arrives is actually, it climbs quite steeply and within reason.

They need things written about it... I think having that support, like community nurses would be the perfect vehicle for that because they do have more contacts sometimes than doctors with the mothers. To say okay, this is available, there's a group starting up, you know, every Tuesday afternoon or

> whatever, or there's some, you know, private group, and here are resources, medical resources, this is a place where you can look, this is a list of books that you can read. Have even lending libraries available ... for mothers who cannot afford ... to buy the books, or they can't get them at the library.... Like have all these resources available... (since) mothers may not even have thought of or know about (PPD). (Andrea)

Women who live with PPD feel hopeless, scared, isolated, and may live with painful memories or recurrent frightening thoughts, that seem to 'come out of the blue'. Health care professionals need to use this information as an opportunity to improve or change their current practices with women living with PPD. That way, we may be able to assist women in their recovery from PPD and in their subsequent identity development, and she will be able to use herself to help others.

Summary

In this study the researcher explored the lived experience of PPD and what helps women at this time. The findings from this study indicated that the lived experience of PPD seems to parallel that of women's identity development. Perhaps, then, the length and severity of her PPD may be dependant on where she is in her process of identity development. A mother works through the process of finding herself while living with PPD. This process is captured in the framework *Becoming Herself Through Postpartum Depression.*

The framework, *Becoming Herself Through Postpartum Depression*, is divided into two sections: the Foundational Challenges, Triggers, Emotional Precursors, which are influential in the mother later experiencing PPD, and the five stages of Becoming

Herself Through Postpartum Depression. These five stages were: Herself for Others, Losing Herself, Uncovering Herself, Finding Herself, and As Herself. Initially, the women in this study worked from a place of being in a role for others, to 'losing themselves' during the pit of their depression, to coming out of this deep depression as they 'uncovered herself', and becoming settled in a place where she has 'found herself' and recovered from living with PPD. For some women, they may reach a place of contentment and peace with earlier life challenges, and discover that they no longer live with fear should they become depressed again in the future since they are content 'as themselves'.

Research to date has focused primarily on the few written accounts of what it is like to have PPD, and some empirical studies on the efficacy of specific medical treatments for women with PPD. Identified literature that discussed the lived experience of PPD was mainly anecdotal and descriptive. The purpose and findings from this study focused on the lived experience of PPD, and what helps women at this time. The findings revealed that a woman moves through her depression towards recovery while at the same time she is also finding herself.

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Appendix A: Information Letter

Project Title: The Lived Experience of Becoming A Mother Through Postpartum Depression

Researcher: Monica Sager, RN Telephone # (250) 544-0134

The purpose in this study is to discover what the lived experience of becoming a mother is like postpartum. To be eligible, you must have given birth within the last five years and had postpartum depression. If you decide to be in this study, you will be interviewed once or twice. Your first interview will be in person and will last for approximately 60 minutes. It will be set at a time that is good for you. I will ask you what your labour and birth was like. I will ask what this experience of becoming a mom was like for you. During the interview, I will ask you more specific questions like how would you describe your relationship with your partner/husband/friend, any recent changes/stressors in your life, previous expectations about your labour/birth/postpartum period, if you have any cultural traditions with respect to birth/postpartum period, and how supported did you feel (emotional/ instrumental support ie laundry, meals, housecleaning). A second interview may be needed to help me understand things you have told me. This interview could be over the telephone and would likely be shorter than the first one. All interviews will be tape-recorded but your name will not be revealed. Instead, a fake name will be used to keep your interview confidential.

A secretary named Karen Thomlinson or Peter Sager, who agrees to keep all information confidential, will listen to the tapes and transcribe the information. Only my committee members and I will read the typed copies. Committee members will not know that it was you. The information will be kept secret. I will store your name, address, and consent form in a locked place that is separate from the tapes. The tapes and typed transcriptions will also be locked up. I will be the only one with the keys. The tapes will be kept for seven years and then destroyed. A report will be written about the study. It may contain some of your own words, but your name will not be mentioned.

You are welcome to join in this study. You can decide to leave the study at anytime, and refuse to answer any question. You can also leave out information at anytime, and ask that it not be used. I will keep everything you tell me in confidence. However, the child welfare act states that child abuse or neglect must be reported.

Child abuse is the mistreatment or neglect of children. Child abuse may be physical, emotional, or sexual. It threatens the well being or security of the child. If you tell me something about child abuse or neglect which is happening, or that a child is at risk, I will talk to you about it, and we will decide together what we will do.

One benefit from joining in the study will be that the information you have shared will be used to help other women who are becoming mothers in the future. If you are interested in joining in on this study, or if you have any questions, I can be reached at the above number. Thank-you for taking the time to consider this study.
Sincerely,

Monica Sager

Appendix B

Informed Consent Form

Project Title: The Lived Experience of Becoming A Mother Through Postpartum Depression

Researcher:
Monica Sager
MA candidate
Faculty of Education
University of Victoria
(250) 544-0134

Thesis Supervisors:
Dr. Norah Trace
Dr. Geoff Hett (721-7783)
Faculty of Education
University of Victoria
(250) 721-7840 (Dr. Norah Trace)

The purpose in this study is to determine what it is like to experience PPD, and to determine what helps women in this process of becoming a mother. The focus of this study will be on your personal experience of becoming a mother postpartum.

Potential participants will be selected from women who have been living with PPD, or who have experienced PPD in the last five years, and who are residing in Victoria, BC. At first, participants from the University of Victoria Family Housing Community will be considered for three reason: 1) the researcher lived in family housing for over four years and became familiar with the manager of the family center who may know of potential participants; 2) this community has families from a variety of cultures and social classes; 3) this community may be more open to participating in student research.

Your participation in this study will involve the following:

-I would like to meet with you to set up a time for the interview.
-You will be interviewed once or twice.
-The first interview will be in person and will last about an hour. The second interview may be in person, or over the phone, whichever is best for you.
-The interview can be done in your home or another place that is convenient for us both.
-The interviews will be tape-recorded by the researcher.
-You will be asked some questions about this birth and previous births if relevant.

Only the researcher and the typist will listen to the tapes. The researcher, typist, and thesis supervisors will read the transcriptions. The tapes and transcriptions will be kept locked-up. The researcher will be the only one with a key. The tapes, transcripts, and notes will be kept for seven years after the end of the study and then destroyed. Consent forms will be destroyed after five years. A report will be written about the study. The interviews may be used for a future study, but additional ethical clearance and consent will be obtained first. The information and findings from this study may be used at

conferences or published in a journal. Some of your comments may be used, but your name will not be used. I will assign a fake name to your comments to keep your name secret.

Your participation in this study is your choice.

-You can decide to leave the study at any time by calling the researcher at the above telephone number.

-You can refuse to answer any question. You can leave out information at anytime as well.

-Withdrawal from the study will have no consequences. Data will be destroyed by incineration if you decide to withdraw from the study.

- There are two possible *benefits* for participants. You may feel a sense of relief after discussing your PPD experience with an enthusiastic listener. You may feel good for sharing your story in order to help women in the future.

This is to certify that I ________________________________ (print name) agree to participate in this research project. I am aware of the purpose of the study and what is involved. All questions have been answered to my satisfaction. I am aware that each interview will be tape-recorded by the researcher. The researcher will keep all information in confidence. However, the child welfare act states that child abuse or neglect must be reported.

Child abuse is the mistreatment or neglect of children. Child abuse may be physical, emotional, or sexual. It threatens the well being or security of the child. If I tell the researcher something about child abuse or neglect which is happening, or that a child is at risk, the researcher will talk to me about it, and we will decide together what we will do. Otherwise, all other information will remain confidential.

If I tell the researcher about an unsatisfactory postpartum experience, the researcher will talk to me about it and assist me to make contact with a counsellor and community health nurse. I understand that I am free to withdraw from the study at anytime. I have been given a copy of this form to keep. The researcher will also have a copy of this form. I can call the researcher or her supervisor at anytime if I have questions or concerns.

______________________________ ______________________

Participant Date

In addition to being able to contact the researcher and the supervisor at the above phone numbers, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate Vice President Research at the University of Victoria (250-472-4362).

If you would like to receive a report of the findings from the study when it is finished, please leave your name and address on the back of this form.

VITA

Surname: Sager Given Names: Monica Ann

Place of Birth: Victoria, British Columbia, Canada

Educational Institutions Attended:

University of Victoria: 1989-1991; 1998-2002
University of Alberta: 1994-1996
Vancouver General Hospital School of Nursing: 1986-1989

Degrees Awarded:

M.N.	University of Alberta	1996
BSc.N.	University of Victoria	1991

Honours and Awards:

Dean's Graduate Award	1999
Graduate Teaching Fellowship	1999
Mary Imrie Louise Graduate Student Award	1995
Helen E. Penhale Graduate Research Travel Award	1995
Cain / Harvey Bursary	1995
Graduate Student Bursary	1994
Undergraduate Student Bursary	1990

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Title of Thesis:

The Lived Experience of Finding Herself Through Postpartum Depression

Author

Monica Ann Sager

March 22, 2002