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The Confluence of Attachment Style, Perceived Social Support, and Role Attainment in Women Experiencing Postpartum Mood Disorders

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LOYOLA UNIVERSITY CHICAGO

THE CONFLUENCE OF ATTACHMENT STYLE, PERCEIVED SOCIAL SUPPORT,
AND ROLE ATTAINMENT IN WOMEN EXPERIENCING
POSTPARTUM MOOD DISORDERS

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

PROGRAM IN SOCIAL WORK

BY

CARRIE J. ENDICK FEIG

CHICAGO, IL

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ABSTRACT

A purposive convenience sample was used in this mixed methods study. Fifteen postpartum women were given four questionnaires and participated in a brief oral interview. The questionnaires included the Edinburgh Postnatal Depression Scale, the McPhee Scale, the Maternal Attitudes Questionnaire, and the Post-Partum Quality of Life. As determined by the questionnaires, a correlation was found between level of competence and level of depression such that the less competent a woman felt, the more depressed she felt. The hypothesis tested in this study was that postpartum depression occurs when complicated early attachments have not been modified by either a sense of efficacy in one's new role as a mother or social supports existing during the time of new motherhood. This study did not confirm the hypothesis. What was revealed through this study was that previous attachment was important, but not the most important mitigating factor in preventing postpartum depression. The most important finding discovered was that perceived support by the new mother was the most protective factor during the postpartum period. Also, postpartum depression was powerfully related to the mother's sense of competence.

CHAPTER ONE

INTRODUCTION

Just as children are absolutely dependent on their parents for sustenance, so in all but the most primitive communities are parents, especially their mothers, dependent on a greater society for economic provision. If a community values its children it must cherish their parents. (Bowlby, 1951, p. 84)

Becoming a mother is one of the most difficult and rewarding experiences that a woman may have during her lifetime. It is an experience that is complicated by numerous historical and contextual factors and introduces unique stress that for some woman may produce feelings of depression. For women, experiencing mood disorders at some time during their life is not uncommon. In fact, the lifetime incidence of mood disorders is twice as great in women compared with men, with the highest risk occurring during the childbearing years (Baugh & Stowe, 1999). Postpartum non-psychotic depression is the most common complication of childbearing, affecting 10-15% of women (Robertson, Grace, Wallington, & Stewart, 2005). This includes all socioeconomic classes (Lemcke, Pattison, Marshal, & Cowley, 2004). The numbers may be greater considering that some women do not seek professional help. If a woman has had a previous history of depression, the rate of postpartum depression increases to 25%, with a 50% chance of reoccurrence (Lemcke et al., p. 97). A recent study of depression during pregnancy and the postpartum period examined 1,400 women and found that 13.5% met criteria for major depression at 32 weeks pregnancy and 9.1% of the women

met criteria for major depression at eight weeks postpartum (Evans, Heron, Francomb, Oke, & Golding, cited in Bledsoe & Grote, 2006, p. 109).

What is unique about postpartum depression is that when a woman experiences postpartum depression, the impact on her family is profound given the effect on the infant, other children, and her partner. The absolute dependence that an infant has on his or her mother for everything, including things as basic as nourishment, exemplifies the potential ramifications of postpartum depression on infants. As a woman experiences the tremendous gain of becoming a mother, she simultaneously experiences the loss of her previously known life. Such timing of maternal depression, one month up until one year postpartum, occurs at a crucial time in an infant's development and impacts the attachment an infant will develop. According to Siegal (1999), an infant's attachment style develops during the first two years of his or her life. Experiencing a depressed mother so early on in an infant's development may set the stage for poorer attachments and future depression for the infant. What further makes postpartum depression different than any other form of depression is that the depression influences two people in critical periods of their personal development.

It has been widely studied and confirmed that the strongest predictors of postpartum depression are depression during pregnancy, anxiety during pregnancy, experiencing stressful life events during pregnancy or the early puerperium, low levels of social support, and a previous history of depression (Robertson et al., 2005). We know some of the factors that may cause postpartum depression or make a woman more vulnerable to experiencing it, but we need to delve further into how these factors interact

and promote greater or lesser risk, especially from within the subjective experience of new mothers. Gaining the perspective of women who have experienced postpartum depression would allow us to gain better understanding of the relationship between three areas: a woman's early attachment style, how she experiences the shift in her role, and the social support that she has during her transition into motherhood. Hearing directly from women may also help us to gain understanding in how to safeguard a woman and her family from postpartum depression by understanding how the women who suffer from postpartum depression experience attachment, shift in role, and social support and how these three factors interact.

Autoethnographic Perspective

I became particularly interested in woman and postpartum depression five years ago when my first child was born. I recognized firsthand how much a woman's world changes and how much support one needs in order to make the transition into motherhood. Now a mother of three, although I have never suffered from postpartum depression, I continue to be interested in gaining a greater understanding of the risk factors and possible mediating factors for postpartum depression. Most of the women I see in my private practice have been referred by their obstetricians and are experiencing some difficulty in the postpartum period. The majority of these women are mildly-to-moderately depressed and experiencing some anxiety. While most women experience depressive and/or anxiety symptoms for a short time with minimal need for intervention, others experience the symptoms for longer periods of time with a greater need for professional support. Because many of the women I see for psychotherapy are also

middle-class, I began to wonder why, if these women have resources and access to care, they are still vulnerable to developing postpartum depression. My clinical experience and review of the literature lead me to propose that this may be the result of their perceptions of their relationships with their own mothers, the role shift that has occurred for them, and their experiences of social support. Because we have almost no data on the subjective experience of postpartum depression, I wanted to test this proposition by hearing from women who are not already in treatment with me as to how they understand their experiences of depression and how they have experienced their transitions into motherhood.

Postpartum depression, as mentioned earlier, is not limited to the first six weeks postpartum, but can occur any time during the first year. Postpartum depression is defined as any major depression within the first year postpartum in which patients have at least five of the following symptoms during the same two-week period:

1. Depressed mood most of the day
2. Anhedonia most of the day
3. Significant weight loss when not dieting, or weight gain, or change in appetite
4. Insomnia or hypersomnia
5. Psychomotor agitation or retardation
6. Fatigue or loss of energy
7. Feelings of worthlessness or excessive guilt
8. Diminished ability to think or concentrate or make decisions
9. Recurrent thoughts of death, or recurrent suicidal ideation, with or without a specific plan. (American Psychiatric Association, cited in Kendall-Tackett, 2005, p. 5, reprinted with permission)

Postpartum depression, like all other mood disorders, affects not only the individual with the current diagnosis, but the entire family and social support system. In

fact, data demonstrate that a mother's postpartum mental-health has profound short- and long-term effects on the mental and physical health of her offspring (Miller, 2009, p. 266). Postnatal maternal depression can preoccupy a mother such that it hinders her infant's behavior, cognitive development, and emotional well-being (Smith, 2004, p. 61). Infants exposed to maternal depression lasting two months or more appear to experience significantly lower weight gain than infants of non-depressed mothers or mothers who experience depressive episodes that last less than two months (Hendrick, 2003). Not only does the mother suffer from postpartum depression; so does her baby.

The age old question of "Which came first the chicken or the egg?" could be applied to understanding postpartum depression when examining family systems and the development of depression. There is constant interplay of current and past factors that influence the development of depression rather than one simple cause. The cultural references to the *chicken and egg* point to the futility of identifying the beginning point of a circular process. A more productive question is, then, what factors maintain the circular process and/or what may disrupt the cycle?

Furthermore, the metaphor of the perfect storm may also relate to this period as women transition into motherhood and possibly experience postpartum depression. Postpartum depression may occur for some women after a complex interaction of elements that are present simultaneously. If the elements mix at a specific time with nothing to diffuse their intensity, a storm, or postpartum depression may ensue. Another important question for clinicians to explore with their clients is what can be done to disrupt the cycle and diffuse the storm as women transition into motherhood?

Family change throughout the life cycle is a topic that Carter and McGoldrick (1989) have written about extensively. They talk about vertical and horizontal stressors, their interface, and how families are affected by change. Vertical stressors include biological heritage, genetic make-up, temperament, and possible congenital disabilities within the family. Patterns of relating carried over from previous generations also add to these vertical stressors. Horizontal stressors include events experienced by the family as it moves forward through time, coping with changes and transitions of the life cycle, various predictable developmental stresses, and unexpected traumatic events, such as an untimely death, the birth of a handicapped child, or a serious accident.

In our view the degree of anxiety engendered by the stress on the vertical and horizontal axes at the points where they converge is the key determinant of how well the family will manage its transitions through life. (Carter & McGoldrick, 1989, p. 8)

Carter and McGoldrick further emphasize the fact that the stress that occurs within a family system is experienced through a unique historical lens that is influenced by the current environment.

In addition to the stress “inherited” from past generations and that experienced while moving through the family life cycle, there is, of course, the stress of living in this place at this time. One cannot ignore the social, economic, and political context and its impact on families moving through different phases of the life cycle at each point in history. (Carter & McGoldrick, 1989, p. 9)

Again, one factor alone does not cause a particular change or problem. Rather it is the combination of past, present, and the meaning made from these experiences that point to the changes in the system. Each family is unique and its experiences are therefore unlike any other families. In a similar manner, the diathesis stress model,

created by Holmes and Rahe (1967), explains behavior as the result of biological and genetic factors (“nature”) and life experiences (“nurture”). This model assumes that a disposition towards a certain disorder may result from a combination of one’s genetics and early learning. It is important to be able to differentiate between what may place a woman at risk for postpartum depression and what ignites a woman’s vulnerability towards a certain problem. Vulnerability is an inherent trait that cannot be realized without stress. According to Ingram and Price (2010), this idea is the essence of the diathesis-stress model as discussed above (p. 15). Pathology can only occur if the vulnerability is present, following the introduction of the risk factors. Like an allergic reaction, a person may not develop symptoms when exposed to peanuts, a potential risk factor, if they do not have a peanut allergy, a vulnerability to nuts. The current research is designed to shed light on the phenomenon of postpartum depression through the unique relationship of attachment, role shift, and social support, as these three factors are a synthesis of innate factors and current experiences; simply nature and nurture converging.

As the literature review below shows, several studies have identified risk factors for postpartum depression, but have not specifically examined the effect that attachment style, role shift, and social support simultaneously play in the development of postpartum depression. It is clear that a deficiency of support and a more insecure attachment style may contribute to the development of postpartum depression. This study however, examines how all three areas together: attachment style, role shift, and social support may impact the development of a postpartum depression or shield a woman and her family from it. More simply, how do these areas work together in the shielding from or

development of postpartum depression? Speaking to postpartum women allows us to obtain women's subjective assessments about their own experiences.

While researchers know what risk factors may be related to postpartum depression and how certain symptoms or experiences may be related to becoming depressed in the postpartum period, we are missing the essential focus of the subjective assessment about how women experience the postpartum period. We need to speak with postpartum women to obtain their subjective assessments about their experiences in the hope that one day we may prevent it and/or ameliorate it.

The goal to prevent a disease/disability and influence a system positively has been a basic cornerstone in social work practice since its establishment as a profession. Social work also focuses on building individual strengths and creating resilience. One specific perspective in social work, the *strengths perspective*, emphasizes empowerment as a means of helping clients to identify and utilize unrecognized capacities to solve problems. The strengths perspective, as a specific separate focus, is a relatively new perspective, but continues to draw on age-old social work traditions that emphasize growth, change, self-help, and development (Saleebey, 1993, p. 155). Asking women suffering from postpartum depression about their experiences can act as an empowering agent for these women. Once individuals' vulnerabilities are addressed, even through a strengths perspective, the environment may still produce risks that stimulate a difficult period. Eda Goldstein (1995) expands on this belief in her book *Ego Psychology and Social Work Practice*, when she writes that "Problems in social functioning must be viewed in relation to possible deficits in coping capacity and the fit among needs,

capacities, and environmental conditions and resources (p. xiii). An individual's experience of a problem not only affects his or her community, but is affected by the community. There is a need to understand individuals' perceptions of what they are experiencing.

This study seeks to advance the knowledge of postpartum depression by examining how a woman describes her perceived level of early attachment style, current social supports, and role shift and how these factors may influence her experience of postpartum depression. In working with women and in reviewing the research literature, common themes have emerged in their narratives that I have witnessed and that the literature supports. These themes include loss, depression, culture, and isolation. It is important to explore these themes because they become trends that are relevant to our theoretical perspective.

Loss

The postpartum period is a period of transition and adjustment for new moms. It is a period of tremendous gain, but also a significant period of loss. Women and families are quick to acknowledge the tremendous gain of the period, the new baby, but recognizing that all the change brings loss as well is something that some women have difficulty accepting and often no place to share. Women need to articulate how they are feeling within a community, so that they can begin to recognize that what they are experiencing is not unusual (Saari, 2002, p. 163). Some examples of losses that women who were part of a focus group have cited when becoming mothers are loss of independence, loss of identity, loss of body image, loss of intimacy, and the routine loss

of sleep. Women shift from being independent to being completely depended upon in a way that inhibits their own autonomy. Judith Viorst (1986), an author who has written extensively on development, states “Our gains and losses are inextricably mixed. There is plenty we have to give up in order to grow. We cannot deeply love anything without becoming vulnerable to loss” (p. 17). In order to understand the postpartum period fully, we need to acknowledge that it is a period in which women simultaneously grow and experience loss. For some women, the period of loss may be accompanied by depression.

Depression

Depression or depressive symptoms may occur in varying degrees in new moms. Depression is twice as common in women as in men between puberty and middle age. Postpartum mood disorders represent the most frequent form of maternal morbidity following delivery (Dennis & Stewart, 2004, p. 1242). In fact, 60-75% of new moms experience symptoms that closely mirror depression but usually do not affect daily activities and do not adversely affect coping mechanisms. The symptoms may include labile mood, tearful episodes, and fatigue. These symptoms usually dissipate within one month postpartum. This cluster of symptoms is known as “The Baby Blues” or “Maternity Blues” (Clayton, 2004, p. 20), and is recognized as a normal part of the transition into motherhood and not indicative of a clinical diagnosis of postpartum depression. The diagnosis of postpartum depression, however, is a depression occurring after one month postpartum and up to one year postpartum and is a well-established clinical phenomenon that presents in 10-20% of new mothers, usually occurring within six months after birth (Vasa, 2006). There is also literature that recognizes that all

women who become mothers, through adoption for example, not just women who have given birth, may experience some depression in the first few weeks or months after becoming a mother. In fact the statistic for mothers who experience depression after adopting a baby in a study that focuses on adoptive moms is similar to the general population who experience postpartum depression, 15.4% (Senecky et al., 2009, p. 62). This evidence supports the belief that postpartum depression is not just a biological phenomenon, but also a psychological and social construct.

Culture

Some researchers argue that postpartum mental illness is “culture bound,” that it is a phenomenon in the United States and some other industrialized nations, but not in other cultures (Stern & Kruckman, cited in Kendall-Tackett, 2005, p. 121). If there is in fact a difference between cultures and the manifestation of postpartum depression, it is helpful to understand why certain cultures are not reporting or experiencing postpartum depression to the degree that the United States of America is. Do we not value the dialogue that other cultures support when women experience the transition into motherhood? It is also helpful to examine our culture to try to understand what may be missing in terms of support or other factors that may contribute to the development of postpartum depression. White middle class and upper class women, like the ones studied in this project, are likely to live away from their families and be on their own before marrying, putting off marriage until they complete their education and launch careers (SOCW 647). This further increases isolation as extended families may be further away and parents may be too old to be able to help. The communities in which the women

studied in this project live are important elements in examining how the women are coping as they transition into motherhood.

Some cultures have rituals built into the transition of becoming a new mother and other cultures emphasize the importance of nurturing the new mother. For example, in Africa, the treatment that the Chagga women experience is different than the experience of American women during the postpartum period.

Three months after the birth of her child, the Chagga woman's head is shaved and crowned with a bead tiara, she is robed in an ancient skin garment worked with beads, a staff such as the elders carry is put in her hand, and she emerges from her hut for her first public appearance with her baby. Proceeding slowly towards the market, they are greeted with songs such as are sung to warriors returning from battle. She and her baby have survived the weeks of danger. The child is no longer vulnerable, but a baby who has learned what love means, has smiled for its first smiles, and is now ready to learn about the bright, loud world outside. (Dunham, cited in Kendall-Tackett, 2005, pp. 122-133)

Rituals like the one cited above not only address the baby's defenselessness, but also focus on the mother's vulnerability. A mother has been exposed following childbirth and needs time to build back her defenses as she begins to understand what it means to be a mother for herself. The ritual also validates the mother and her accomplishment of creating and sustaining life. Acknowledging a mother's vulnerability through support may be a way not only to address postpartum depression, but also perhaps to prevent it.

Isolation

In contrast to other cultures, many American women report that once their baby comes, all attention is on the infant and they feel an overwhelming feeling of being alone. Often American women feel that their accomplishment of creating life is not

acknowledged and they are left to feel isolated and insecure and not sure what to do. Daniel Stern further illustrates the phenomenon of American women facing virtual isolation when they are newly transitioning into motherhood when he describes how modern cultures differ from traditional cultures. In traditional cultures, women are usually surrounded by other women who are not necessarily part of their family. He explains that currently women try to recreate the traditional village of other cultures by calling and e-mailing, but generally, women are essentially alone with the exception of their husbands (Stern, cited in Brown, 2005, p. 16). Whether postpartum depression is strictly found in industrialized cultures or not, it does not negate the facts that it can be lethal and that it needs greater understanding.

There continue to be a number of obstacles to preventing and understanding postpartum depression that include patient and public lack of awareness and confusion about availability and accessibility of community mental health resources. Although several studies have identified and implemented some ways to identify postpartum depression and even recognize depression during pregnancy, there continue to be risk factors that have not been identified.

If risk factors are identified more precisely, there may be ways to prevent and hopefully eliminate and/or ameliorate postpartum depression. Prevention not only helps the woman at risk from postpartum depression; it also facilitates a woman's successful connection with her baby, which helps to inoculate the baby from depressive symptoms as well. Consequently, preventing postpartum depression helps an entire family system which includes future generations. The long-term effect of a positive impact on a family

system can help horizontal and vertical stressors as described by Carter and McGoldrick (1989).

There has been a paucity of empirical research on the nature, course, and treatment outcome of depressive disorders that occur during pregnancy and the postpartum period. Although a host of biopsychosocial risk factors have been identified to influence the onset of mood disturbance postnatally, depression in the postnatal period continues to be present. Some of these risk factors may include lower socioeconomic status, adolescent motherhood, dysfunctional partner relationships, poor social support networks, and other stressful life events (Clayton, 2004, p. 20). Research on the confluence of such factors on depressive disorders that occur among women at different points in time has been relatively scant, particularly in the area of hearing the voices of these women.

This research has the unique goal of beginning to understand the sociological and psychological interplay of early attachments, role adjustment, and social support for women in the postpartum period as described by the women themselves. Determining the relationship between these three factors and the development or absence of postpartum depression will be the guiding focus of this research.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

Risk factors for postpartum depression exist and certainly can be identified. However, what truly sets off a woman's vulnerability to developing postpartum depression has not been concretely determined. Michael O'Hara, associate dean and professor at the University of Iowa's Department of Psychology and researcher in postpartum depression, has concluded that socioeconomic factors, which include low education level, contribute to depression not only during pregnancy, but also after pregnancy (O'Hara, cited in Rosenberg, Greening, & Windell, 2003, p. 38). In this sense postpartum depression reflects the epidemiology of other forms of depression, which we have known for some time are exacerbated by poverty. O'Hara's studies help confirm that there may be risk factors during the prenatal period that serve as an early warning sign that women may be at a higher risk for developing postpartum depression. Nevertheless, for some women, despite understanding specific risk factors and addressing them, postpartum depression continues to exist.

The literature on postpartum depression has been consistent but not extensive. It confirms that there are several risk factors that make a woman more susceptible to postpartum depression. These risk factors include limited support, previous depressive episodes, depression during pregnancy, low self-esteem, and marital conflict (Posner, Unterman, Williams, & Williams, 1997). Also, some research indicates that the

relationship that a new mother has with her own parents and other individuals, usually friends, in addition to support from a spouse may determine her psychological adjustment to motherhood (Richman, Raskin, & Gaines, 1991, p. 144). These findings lend evidence to the belief that current social supports affect our later relationships, namely our relationships with our children.

Research in early development has demonstrated that early attachments affect our experiences of future relationships, but there are also other parts of our experiences, such as the amount of social support we experience, how we perceive it, and the way we recognize our own role shift during certain transitions, that may affect our development during the postpartum period. Prior research does not, however, discuss the simultaneous influence of attachment, role shift, and social support on the development of postpartum depression or the women's perceptions of these variables and how they affect the postpartum experience. This research aims to examine, by studying women's subjective experience when early attachment, role shift, and social support are examined together, if there is a connection with postpartum depression. Consequently, three theories are particularly relevant for this project: (a) Attachment, (b) Role shift, and (c) Social support. I will further explain each theory below. As a post-positivist, I plan to use these theories to guide my questions, but I also plan to provide room for the women to discuss the meaning these variables have for themselves in the postpartum period and learn about their subjective experiences about how these variables interact in precipitating their experiences of depression. In other words, the theories will guide my questions, but will not limit the exploration of these women's narratives.

Attachment

The connection that one feels towards another individual has a profound effect on one's experience, one's development, and one's overall functioning. Object relations theorists were among the first to discuss the importance of the actual relationship between caregivers and their children, and as a member of that group, John Bowlby became famous for his work on attachment. Object relations theorists understood that the relationship between family members had an influence on individuals and their future relationships. According to Bowlby (1969), the behavioral development of an individual needs to be considered in two distinct ways: (a) the way in which the parts of the behavioral equipment in active use changes from one phase of the life-cycle to the next and (b) the way in which each part of that equipment comes to take the particular form it does. This emphasizes that instinctive behavior is never understood in terms of a single individual, but in terms only of a population of individuals collaborating together (Bowlby, 1969). There is interplay from generation to generation and within family systems.

Bowlby (1969) wrote extensively on the attachment and development of many species from birds to humans. His ideas related to attachment and the influences of the environment are the core of this project.

In other species and for other behavioral systems the changes are environmentally labile and the form they take in the adult is much influenced by environmental variation. In such cases the period during which they are sensitive to change in the environment is often of only limited duration, and is termed a "critical phase" or "sensitive" period. (p. 147)

In simpler terms, the time period during infants' development shapes their attachments to early caregivers, which will ultimately affect their relational behaviors as adults.

According to Bowlby (1969), there are different ways that infants may attach to early objects during their own early development. Some infants may avoid attachment or have ambivalent feelings regarding attachment. Later in development, infants who were ambivalent about attachment may be defensive regarding relationships and maintain a self-protective stance towards relationships. In other words, some adults may crave attachment, but at the same time push relationships away. Numerous studies and tests have studied adult attachment patterns and made the connection to earlier childhood attachment patterns. Early attachments create expectations or working models that are theorized to play a critical role in the strategies and goals adopted by the child to regulate his or her emotions and social behaviors (Simpson & Rholes, 1998).

Whether an adult is secure or insecure in his or her adult relationships and the relationship with his or her children may be a partial reflection of his or her attachment experiences in early childhood. Bowlby (1969) believed that the mental representations or working models (i.e., expectations, beliefs, "rules", or "scripts" for behaving and thinking") that a child holds regarding relationships are a function of his or her caregiving experiences. For example, a secure child tends to believe that others will be there for him or her because previous experiences have led him or her to this conclusion. Once a child has developed such expectations, he or she will tend to seek out relational experiences that are consistent with those expectations and perceive others in a way that is colored by those beliefs. According to Bowlby, this kind of process should promote continuity in

attachment patterns over the life course, although it is possible that a person's attachment pattern will change if his or her relational experiences are inconsistent with his or her expectations. In short, if we assume that adult relationships are representative of attachment relationships, it is possible that children who are secure as children will grow up to be secure in their romantic relationships and their relationships with their own children.

I propose that because of early attachment styles, some women are more susceptible to developing postpartum depression. "Highly ambivalent people, therefore, face a difficult dilemma; they crave support and are unhappy without it but, because of their working early developed models, they also perceive that the support available to them is inadequate" (Simpson, Rholes, Campbell, Tran, & Wilson, 2003). According to Bowlby (1969), a woman's attachment style, how she formed early attachments, when activated by stress may influence how she reacts during the postpartum period.

A woman's early attachment style to early objects often helps to illuminate how she may adapt during the postpartum period. Each individual woman constructs her vision of motherhood within a multitude of relationships. As humans, our survival has been influenced by our ability to attach and to form relationships. Object attachment is a primary, built-in feature of human functioning. We have survived as a species because we do not stray from one another and literally wander into the darkness (Pine, 1990). As humans we long for connection. As a woman enters into another stage of her life and braces herself to attach to her new baby, it stands to reason that how she built attachments during her own early years will influence this new stage of her development. Main,

Kaplan, and Cassidy (1989) have shown that one of the most reliable predictors of how a new mother will act with regards to attaching to her new baby is how she was with her own mother when she was a little girl (Brown, 2005, p. 15). What was modeled for women in terms of attachment can certainly be recognized through this transition period.

Supporting Bowlby's (1969) speculations regarding attachment, highly ambivalent women who entered the transition to parenthood perceiving their husbands were less supportive and angrier experienced significant pre-to-postnatal increases in depressive symptoms (Simpson et al., 2003). Women seemed to experience the same kind of unsupportive relationship with their husbands that they had had with their own mothers. The attachment style that women had with their mothers was recreated in adulthood with their husbands and could alter women's perceptions of the support they were receiving. In Simpson et al.'s study, the Diathesis Stress Model further supported the belief that how we attach early will shape our relationships later on in life.

Across a common, major life stressor, it reveals the way in which a theoretically important personal vulnerability as demonstrated by an ambivalent attachment interacts with important interpersonal perceptions. These negative perceptions include, but are not limited to, negative prenatal perceptions of spousal anger and support. Negative perceptions may forecast increases in depressive symptoms for women. (p. 1173)

We are shaped by our early experiences, which influence the choices we make about relationships and also how we perceive present situations.

Furthermore, with attachment, there is an emphasis on the mutual nature of the relationship between the infant and the caregiver in Bowlby's (1969) work. A mother

will influence the way an infant becomes attached to her and the way an infant responds to his or her mother will influence the mother's reactions.

He [the infant] greets and approaches her [his mother] and seeks her attention in a thousand attractive ways. Not only does he by these means evoke responses from his companions but "he maintains and shapes their responses by reinforcing some and not others" (Rheingold, 1966). The pattern of interaction that gradually develops between an infant and his mother can be understood only as a resultant of the contributions of each, and especially of the way in which each turn influences the behavior of the other. (Bowlby, 1969, p. 204)

The above quoted passage illustrates that attachment may be influenced by earlier experiences, but can be reshaped with new events. Powerful, early attachments are not invincible; in fact there is evidence to suggest that they can be altered by subsequent relationships. The reciprocity of a mother and infant's interaction highlights the fact that the behavior of the mother and baby together is what creates the attachment. Daniel Siegel (1999) illustrates this in his book *The Developing Mind*, which places a current neurobiological perspective on the theory of attachment. He emphasizes the idea of "feeling felt," which is the idea that infants have their needs met as their mothers or caretakers are attuned to their needs.

Not only were Bowlby's (1969) ideas in attachment revolutionary, but Siegel (1999) also supported the significance of attachment and the way it continues from generation to generation. Siegel proposed that repeated patterns of children's interactions become imprinted in the brain and shape future relationships. These interactions become an autobiographical narrative that influences communication within relationships and facilitates the development of the mind (p. 6). If the mind is continually developing,

perhaps behavior and perceptions can be changed through different narratives in an effort to heal the patterns that are dysfunctional. This research aims to understand postpartum women's narratives in an effort to safeguard future mothers from experiencing postpartum depression.

Mary Ainsworth was another researcher who contributed to the formulation and development of attachment theory. Her contributions further expanded Bowlby's (1969) previous work by emphasizing the belief that although a developing child has a predisposition to form attachments, the true nature of those attachments depends on the environment to which the child is exposed. Her research was based on Bowlby's early discoveries and focused on the infant-toddler period. She introduced the concept of the "secure base." Her studies identified four attachment patterns that a child may have with his or her primary attachment figure: secure, anxious-avoidant (insecure), anxious-ambivalent (insecure), and disorganized (Main, Kaplan, & Cassidy, 1985). In a secure attachment pattern, the caregiver will respond appropriately, promptly, and consistently to the needs of the infant-toddler. In the avoidant attachment pattern, the caregiver will provide little or no response to the distressed child. The caregiver will also encourage independence and discourage a child from crying. In an ambivalent attachment pattern, a caregiver will provide inconsistent and neglectful responses to the child's needs. Finally, in a disorganized attachment pattern, a caregiver will demonstrate frightening behavior, intrusiveness, withdrawal, negativity, role confusion, and maltreatment.

As children develop, they form specific attachment patterns. These patterns then become part of an internal working model in adulthood. Some authors have suggested

that an adult's internal working model regarding attachment does not involve a single perspective, but rather a hierarchy of models containing general ideas about close relationships. Furthermore, within those close relationships, different ideas about attachment may be formed (Pietromonaco & Barrett, 2000). Reactions to attachment may shift as an adult experiences different things and has new relationships. With the life altering experience of becoming new mothers, women are brought back to their internal working models as they form new attachments with their infants.

Adjustment to Motherhood

A woman's adjustment to motherhood is directly correlated to her experience with others and, as the above researchers postulated, to the environment in which she is exposed. Therefore it can be recognized that a woman's adjustment to motherhood has two components: intrapsychic and interpersonal/social. Intrapsychically, it can be observed that attachment begins in early childhood and continues to take shape interpersonally as women have different experiences. According to Nancy Chodorow, "Motherhood is a conscious and unconscious fantasy first and foremost: a gendered bodily, object-relational, and cultural experience for women." She also states that women draw on their own experiences of being mothered when they make the transition into motherhood (Chodorow, cited in Brown, 2005, pp. 138-139). Quite simply, women do not enter into motherhood as blank slates. Their adjustment to motherhood is shaped by their current and past relationships and their mental representations of those relationships. From an object relations point of view, not only is the "real" relationship key in the psychological development of an individual, but the internal mental

representations of others is fundamental to development (Berzoff, Flanagan, & Hertz, 1996, p. 128). Understanding a woman's early development and how she perceives her support systems may serve to illuminate risk factors for postpartum depression further.

Our early relationships help to shape our current relationships in both positive and negative ways. Early during a child's development, his or her personality will emerge. Personality influences everything from attachment to how someone will understand the world around them. A person's lens and how he or she views things thus begins to develop very early on in his or her development. How maternal personality factors in facilitating or interfering with attachment continues to be an area that needs to be explored. Women who have had disrupted or inadequate mothering themselves should be considered at a higher risk for attachment disorders (Frommer & Shea, cited in Stotland & Stewart, 2001, p. 123). New mothers who have had a history of parental rejection and few expectations of having others respond to their needs may relate to current relationships by not asking for their needs to be met or engaging aggressively to get what they want. Either way, their past experiences shape their current expectations and may increase the likelihood of depression (Crockenberg & Leerkes, 2003).

Fraiberg, Edelson, and Shapiro's (1975) article *Ghosts in the Nursery: A Psychoanalytic Approach to the Problems of Impaired Infant-Mother Relationship* examined whether a mother who had a difficult childhood would repeat some of the negative experiences with her own infant. The article hypothesized that the difference between mothers who repeat the conflicted past and those that do not is in the nature and content of the defensive repressions. More specifically, the mother who successfully

isolates and represses the affective components of the trauma seems doomed to repeat the pathological parenting through identification with the betrayers and the aggressors. In other words, the “ghosts in her childhood nursery” interfere with hearing the cries of her own infant. The mothers who consciously retain the effects of their painful past, however, are less likely to repeat the same conflicted experience (Fraiberg, Edelson, & Shapiro, 1975). Could it be possible that if a woman has an environment that will allow her to articulate her experiences, she may be less likely to repeat negative behaviors? Now we would say that the woman actually internalizes new relationships, altering her inner life, and thereby modifying her experience of the previous working models. Research that examines this process needs to be done, which is the purpose of this dissertation. More simply, it needs to examine these models and the environment in which these working models get reintroduced in the present. A woman’s environment is synonymous with the next area of concern within this project: social support.

Social Support

Just as the environment is critical in childhood, it continues to be critical in adulthood. A woman’s environment is her social support network: who she can lean on, who she can call, and basically, who she can rely on. The social support literature discusses three main types of social support in examining women who develop postpartum mood disorders. These three types of support include general support, partner support, and the impact of the social network (Kendall-Tackett, 2005, p. 114). General support includes the network of people with whom the mother shares interests and concerns and can count on for help in any circumstance. Partner support can either come

from a spouse or a partner who may be helping to raise the child. The impact of the social network includes the size of a woman's network, proportion of kin, frequency of contact, and reciprocity in supportive interactions.

The literature discusses a buffering effect that social support may provide for some individuals when undergoing a stressful event. However, as the literature highlights, it is important to recognize that for each individual it may not be the fact that there is actual support, it is the perception of whether or not there is support present and if it is in fact helpful (Cohen & Wills, 1985). As the literature about support grows, it appears that women who have had difficulty in the postpartum period are more likely to have experienced psychosocial problems such as relationship distress, especially where there is a lack of emotional and practical support from their partners (Ohara & Swain, cited in Griffiths & Barker-Collo, 2008).

It has been confirmed that women who feel like they are isolated in their transition to motherhood are at an increased risk for postpartum depression (Burgha et al., cited in Rosenberg et al., 2003, p. 37). The researchers have confirmed that a woman's adjustment to the postpartum period is intimately linked to the quality of the relationship with her partner (Zelkowitz & Milet, cited in Stotland & Stewart, 2001, p. 118). Other research however, confirms that support does not only pertain to the father of the baby, but it also includes other general support and social networks. Cutrona (cited in Stotland & Stewart, 2001) found that the availability of companionship and a feeling of belonging to a group were more important predictors of good adjustment in the postpartum period than was intimacy with a husband (p. 125). Generally, women who feel that they are

cared for by partners, relatives, husbands, and friends, have a lower rate of postpartum depression (Gjerdningem & Chaloner, cited in Rosenberg et al., 2003, p. 37). According to one Danish study, reported in the *British Journal of Obstetrics and Gynecology* in 2000, one out of three women who perceive themselves as socially isolated will develop postpartum depression (Rosenberg et al., 2003, p. 37). It seems well established that the postpartum period should not be faced alone by a mother. Social support can mediate current symptoms and can come in various forms, including psycho-educational. Women can be taught how to evaluate who is supportive in their lives and how to ask for more help. Women can be shown how to advocate for themselves in order not to be so isolated. It is important in understanding postpartum depression to examine not only relationships experienced as past, but also relationships existing in the present, since perhaps depression occurs when present relationships are not modifying unsupportive working models. In a multi-method, multi-dimensional study, 208 African-American women between the ages of 14 and 21 were interviewed during the second trimester of pregnancy and again when their infants were 4 and 12 months old. The study supported the idea that young mothers experiencing depressive symptoms may benefit from psycho-educational or social support interventions that focus on providing information about normal infant development and normal challenges associated with parenting an infant (Edwards, Thullen, Isarowong, Shiu, Henson, & Hans, 2012). If women have more support, through education, for example, their transition into motherhood, as they experience a role shift from independent women to mothers who are depended on, may be smoother and feel less frightening.

Role Shift

The third facet of this research is the idea of change in role. Through our development, as we grow, we experience some periods in which our roles change. How we experience these changes has been highlighted in the sociological literature through the study of role theory. Role theory is a perspective in social psychology that holds that most of everyone's everyday activity is focused on living up to roles or expectations of others. Furthermore, according to Sandler's 1976 concept of "role responsiveness," people continuously attempt to reestablish earlier relationships with others in their attempts to understand their current roles (Frankel, 1995). In order to understand role theory, several components need to be considered: role shift, role identification, role attainment, and role complexity. As a woman becomes a new mother, she is experiencing a role transition and attempting to understand her new role in terms of earlier relationships. Another component to this role shift is the fact that many women enter into their pregnancies feeling ambivalent about becoming mothers. Akin to any big life change, individuals are often faced with mixed feelings. Perhaps this is due to the unknown and the fear that although we think we may want something, the known situation feels safer than the unfamiliar. This feeling of ambivalence, which is normal, is not only uncomfortable, but may increase a woman's fear of being an adequate mother if she feels that she cannot even be overjoyed about her new baby.

Choosing Motherhood

With ambivalence as just one example of a feeling that some women may have when entering into motherhood, the transition into motherhood is something that is

experienced very differently for every woman. Why a woman chooses to become a mother is also a very individual decision. Nancy Chodorow writes extensively about why women mother in her 1978 book, *The Reproduction of Mothering*. She postulates that

The biological argument for women's mothering is based on facts that derive, not from our biological knowledge, but from our definition of the natural situation as this grows out of our participation in certain social arrangements. That women have the extensive and nearly exclusive mothering role they have is a product of a social and cultural translation of their childbearing and lactation capacities. It is not guaranteed or entailed by these capacities themselves. (p. 30)

The expectation for women to mother may play a key role in the development of postpartum depression. Today, as women are struggling to choose between career and family, the decision to have a family has shifted from being a necessity to becoming an option (Chodorow, cited in Brown, 2005, p. 136). Women have more options in the roles they choose, are having children later in life, and are struggling to find the right balance for themselves, family and career. The amount of support they have may influence how they face the actual challenge of being a mother and whether they choose to become a mother.

As mentioned before, there are several aspects of role that include role identification, role attainment, and role complexity. These areas help to illustrate the fact that role is a complex area that has different nuances that affect the comprehension of its meaning. The next section will help to illuminate role through the examination of its different aspects.

Role Identification

One primary relationship that women begin to examine naturally during this role shift is their relationships with their own mothers (Rosenberg et al., 2003, p. 28). It is a natural instinct to look for guidance within a woman's own relationship with her mother as she becomes a mother. This instinct occurs intrapsychically. With the transition into motherhood, a woman has the opportunity to rework and resolve her own childhood conflicts and achieve a new level of maturity (Benedeck, cited in Goldstein, 1995, p. 106). This also emphasizes the social aspect of becoming a mother. As a woman is evolving and redeveloping her identity during this period she may be struggling to define herself no longer in terms of her marriage or just as a parent. Therefore, she may feel lost in terms of role identification. This loss of role may be inherent in the symptoms that develop into postpartum depression.

Role Attainment

Maternal role attainment is the process through which a woman achieves a sense of competence in carrying out mothering behaviors. Mothering behaviors include nurturing and caring for an infant. These behaviors are then integrated into her established role, or sense of self (Fowles; Mercer; Rubin, cited in Hart & McMahon, 2006). The process of developing a maternal identity begins during pregnancy, continues after the birth of an infant, and helps an infant and mother build an emotional tie (Rubin, cited in Hart & McMahon, 2006). Every mother and infant is a unique unit and attachment occurs at different rates for each mother and infant. Just like one infant will sleep through the night at six weeks and another baby may not sleep through the night

until he or she is closer to one year, every baby and his or her development occurs at different rates. A woman's self-efficacy as a parent is likewise shaped by each experience with her infant. For example, a baby that is difficult to soothe makes it difficult for a mother to feel competent, particularly if this is a first child and she doesn't have anything else with which to compare it. Clearly, establishing this new role is a process for the mother which develops over time and cannot be precisely measured.

Miller-Heyl, MacPhee, and Fritz (1998) further demonstrated the idea about parental efficacy and competence in research that involved a multi-level prevention program DARE to be you, aimed at 2-5 year olds in high-risk families. They wrote about the self-fulfilling prophecy that is ignited when mothers begin to question their efficacy.

They write:

If a mother perceives herself to be an ineffective parent—a socially important role—her feelings of self-worth are likely to be low. These poor self-appraisals may in turn engender a sense of hopelessness about the ability to become effective. (p. 281)

The new role that a woman begins to attain as she develops into a mother is deeply rooted in her perception of herself. It is a complicated role that has ties to her early development. The richness of the new role is a complex synthesis of who the woman is and who she is trying to become as a new mother. What complicates this idea is that as the woman attains the role that she thinks she wants, things are forever shifting. For example, just as a mother masters one developmental task, the baby may change his or her napping or feeding schedule. Another factor is that mothers may find themselves responding to the different phases of their child differently, for example, some mothers

may enjoy infancy but not toddlerhood. The age-old question: “What do mothers want?” becomes critical here, as mothers’ needs are not on a straight trajectory. There is no simple answer to this question and the answer is forever shifting.

Role Complexity

As a woman begins to understand her new role as a mother, it is important to recognize that women often maintain several roles. For example, women are never just mothers; they may also have a career. Just as an individual’s experience with early attachment will not be the only factor affecting a current relationship, a woman may transition into a new role while simultaneously trying to maintain other roles.

Many women have spent years pursuing careers that have brought them much satisfaction and formed an important part of their adult identity. The prospect of motherhood may threaten this aspect of their sense of self. (Brown, 2005, p. 157)

For a new mother, the shift into motherhood takes time and other current roles should be considered as a woman is attempting to establish herself as a new mom. Indeed this is a period where figuring out one’s identity is a complex undertaking. For example, to mention a few roles, a mother may be caring for her own aging parents, raising children, and maintaining a relationship with a partner. Also, a woman may manage a professional role that she maintained prior to pregnancy. According to Epstein (1987), a woman’s ability to adapt to dual roles or identity complexity is related to the support that she receives from those around her.

Such identity complexity, it has been supposed, can be created only through a combination of active participation in social events and empathic interaction with others. (Saari, 2002, p. 163)

This adaptation, figuring out one's identity, is not stagnant. Mothers are constantly trying to create a balance between what they knew to be themselves and the new identity that they are trying to create.

Even with the most liberated and supportive spouse or partner there will be what we would call "role strain." For instance, even a woman who loves her job will occasionally experience guilt about the time it takes away from her child. Conversely, no matter how much a woman loves her child and the role of mothering, there are bound to be times when she resents the sacrifices she may be required to make at work to be a good-enough mother. (Brown, 2005, p. 157)

With a lack of support, both concrete and emotional, a woman's ability to cope is diminished. Not coping well may lead to depression. At the very least this must fluctuate on the normal body's reaction to sleep deprivation, let alone the lack of support. The physical challenges may be the maximum of what some women can handle. When you add a lack of support, the scale gets tipped.

A study that confirms that a strong support system, specifically through a strong foundation of friendship between a husband and a wife, nurtured consistently throughout the marriage, could increase marital satisfaction during the life-changing experience of having a child (Shapiro, Gottman, & Carrere, 2000, p. 59). Friendship, a relationship synonymous with support, may make a woman more resilient to feeling unhappy when becoming a parent. When a woman felt that her husband expressed fondness toward her and there was a mutual understanding of each other within the relationship, a decline in marital satisfaction was less likely to occur. The less alone a woman feels, the more protected she is from experiencing difficulty in the postpartum period.

How can we take preventive measures to help reduce the occurrences of postpartum depression? In order to help women who are experiencing postpartum depression, we need to understand the risk factors. If we understand that postpartum depression is a potentially healthy process towards psychological integration and personal growth, rather than a pathological response to an event that is believed to be filled only with bliss mixed with a bit of sleep deprivation, we may be able to help more women through the transition to motherhood (Nicolson, 1999). The postpartum period represents a continuum of adjustment that may range from sadness related to hormonal reactions to an extreme of psychotic depression. It is a process rather than a single defining event. We often try to treat disorders without really understanding their manifestations or the different processes that may work in concurrence to produce the disorder.

There are many ways in which to understand any given environment and/or situation. Yet if there are many ways to understand any given situation, then there can be no correct or healthy way to react to the situation. (Saari, 1993, p. 12)

The first step in treating any problem is listening to how the individual has experienced the conflict. After hearing many experiences, it is hoped that some commonality exists, so that positive change may lead to the extinction of the problem.

CHAPTER THREE

METHOD

Postpartum depression occurs in a complex web of variables. In working with the phenomenon, we have moved beyond a linear concept of cause and effect. We know that specific risk factors will produce symptoms of postpartum depression. Therefore, a quantitative study could only reduce postpartum depression to simplistic variables. Due to the interface of causing factors, there is the need for multiple systematic interventions and we cannot get to that point until we can see more of the cause so we are able to frame how to help.

The knowledge that any observation yields is totally dependent upon the lens through which the observation is made (Bronowski, 1978). There are many ways to understand any given environment and/or situation. Yet if there are many ways to understand any given situation, then there can be no one correct or healthy way to react to that situation. (Saari, 1993, p. 12)

This study proposes that it is important to look at the issue of postpartum depression from a mixed-method design, using various vantage points: attachment, social support, and role shift in order to move beyond specific risk factors and determine the influence of the three aforementioned areas together. I hope to determine if a woman's perception of her early attachment experiences, social support, and role shift somehow work together to protect against or influence the development of postpartum depression. I wish to hear about postpartum depression through individual voices that cannot simply be quantified.

From a postpositivist standpoint, the aim of research is solving problems. In appraising a theory, postpositivists do not focus on which theory is “true” according to some abstract criterion. Rather, they assess whether a given theory is an improvement over alternatives, including whether the researcher regards it as closer to the truth and more useful than the alternatives. (Heineman Pieper, cited in Tyson, 1995, p. 225)

Design Description and Procedures

Design Description

A mixed methods approach enables a more nuanced and in-depth understanding of the relationships between attachment, role shift and social support, and post-partum depression including how they may inter-relate. Furthermore, the study of postpartum depression is a personal, lived experience; hence, it indicates a qualitative approach. Because a phenomenological study attempts to describe the meaning of the lived experiences for several individuals about a concept or phenomenon (Creswell, 2002, p. 51) this specific form of qualitative inquiry is best suited for the topic under exploration.

Many mixed methods studies are descriptive and exploratory; they build rich descriptions of complex circumstances that are unexplored in literature. Other qualitative studies are explanatory; they show relationships (frequently as perceived by the participants in the study) between events and the meaning of the relationships (Marshall & Rossman, 2011, p. 33). This study aims to be descriptive, exploratory, and explanatory in order to address the complex nature of the origins of postpartum depression from the mothers’ perspectives.

Research Questions

This study addresses the following research questions:

1. Does complicated attachment, as reported by mothers with postpartum depression, correlate with greater difficulty in the postpartum period?
2. Is there a correlation between the difficulty a woman has in identifying her role as a new mother and the likelihood of depression in the postpartum period?
3. Are women who perceive a higher level of social support less likely to report feeling depressed?
4. How do the mothers experience the interaction of these variables with each other?

Specifically, the hypothesis is that postpartum depression occurs when complicated early attachments have not been modified by either a sense of efficacy in one's new role as a mother or social supports existing during the time of new motherhood.

Procedures

Sampling plan. A purposive convenience sample was used in this study. According to Polkinghorne (2005), "The purposive selection of data sources involves choosing people or documents from which the researcher can substantially learn about the experience" (p. 139). All participants came from Wellsprings Health Associates, which is a women's mental health practice. Women who come to Wellsprings are seeking treatment for many different reasons. Some are struggling with life changes, mental or physical illness, or simply wanting to talk to a health care provider about dissatisfaction in some areas of their lives. All postpartum women were informed about

the study by the intake coordinator when they called to schedule their first appointment at Wellsprings Health Associates. The final sample was composed of 15 postpartum women. Although small, this sample size is generally considered to be sufficient for the qualitative research goal of eliciting recurrent themes (Rennie, Phillips, & Quartaro, cited in Coady & Wolgien, 1996).

During the initial telephone call to Wellsprings, in which a patient called to set up an initial evaluation, the Wellsprings' intake coordinator presented the study to all new patients and answered any preliminary questions. Women who were interested in participating in the study were asked to arrive thirty minutes prior to their diagnostic intake appointment in order to obtain informed consent before completing any questionnaires. There were no exclusion or inclusion criteria regarding age, religious background, or racial/ethnic background. Most of the women were referred to Wellspring by their obstetricians after their doctors recognized symptoms or they themselves recognized that they were having a difficult time in the postpartum period and asked for referrals.

Variables/Main Concepts

Measures and Instrumentation

The main variables considered in this study were attachment, role shift, social support, and postpartum depression. The qualitative variables that emerged from the data were predetermined. I wanted to understand each woman's unique experience and how attachment, role shift, and social support related to each other and how they related to postpartum depression as a unit. In addition to these variables, I collected some basic

descriptive data upon intake. These quantitative variables included age, race, marital status, education, income, Edinburgh scores, the Postpartum Quality of Life Measure, (PP-QOL), Maternal Attitudes Questionnaire (MAQ), and the McPhee Scale

Postpartum depression was measured by the Edinburgh Postnatal Depression Scale (EPDS) (see Appendix A). The EPDS was developed at health centers in Livingston and Edinburgh. It was developed to assist primary health care professionals to detect mothers suffering from postpartum depression. The EPDS, which has been widely tested, has been utilized in 23 countries and carries a significant level of sensitivity (86%) and specificity (78%) in identifying those at risk of or potentially suffering from either prenatal or postpartum depression. The EPDS is a ten-item scale, typically self-administered, requiring about five minutes to complete (Cox, Holden, & Sagovsky, 1987).

Social Support was measured using the PP-QOL (see Appendix B). The PP-QOL is a scale with acceptable reliability. It is the first self-administered instrument that measures maternal quality of life during the early postpartum period. The sample that was initially given the PP-QOL was a convenience sample of 184 mothers at weeks 1 and 3 postpartum (Hill, Aldag, Hekel, Riner, & Bloomfield, 2006).

Role identity was measured by the MAQ (see Appendix C). The MAQ is a 14-item self-report instrument measuring thoughts related to role change, expectations of motherhood, and expectations of the self as a mother in postnatal women. In 483 women who were 6-8 weeks postpartum, scores on the MAQ were found to be highly correlated

with the EPDS. The MAQ has good test-retest and internal reliability (Warner, Appleby, Whitton, & Faragher, 1997).

The McPhee scale is designed to measure competence and self-efficacy in the parental role (see Appendix D). I decided to not use the adult attachment interview because that scale focuses on childhood experiences and places the participant taking the scale in one of three attachment categories: autonomous, dismissive or preoccupied. For this study, the specific attachment style was not being sought after; rather the experience of the attachment through self-perceptions. The McPhee Scale is a 22-item self-report instrument that measures self-perceptions of the parental role. Within the scale there are four smaller scales that measure investment (importance), competence, satisfaction, and integration (or parent, spouse, career, and friend roles). These four smaller scales better highlight the nuances of what these study participants were experiencing when correlated with the oral interviews. There are two statements per item which describe contrasting endpoints of hypothetical parents' feelings, attitudes, or behaviors (McPhee, 1986).

For the qualitative portion of this study, 11 questions were asked (see Appendix F). A focus group examined the language that women used to describe attachment, social support, and role shift in order to create the questions used in this study. Due to the fact that this study was subjective, in order to capture the phenomenon of attachment most effectively, these questions were also influenced by the adult attachment interview. The adult attachment interview is a procedure for assessing adults' strategies for identifying, preventing, and protecting the self from perceived dangers, particularly dangers tied to intimate relationships (George, Kaplan, & Main, 1986, 1996).

All study participants were given a consent form upon arrival for their first appointment. This form was completed before any study procedures began. All data were held in the strictest confidence. Each participant was given an ID number that was used on all subject documents, files, and databases. Names were not marked on any questionnaire materials. One master list matching respondent names and ID numbers was maintained by the private investigator in a secure file. All study records were maintained in a locked cabinet at Wellsprings Health Associates.

No harm appeared to occur to participants as a result of their participation in this study, during the survey or interview process, however it was possible that as a mother reflected on her experience, she may have become distressed either from current feelings or from discussing the past. Participants were notified in the consent and were told that they could cease participation at any time and that the researcher would be available to debrief and provide support at any time during study participation.

Data Analysis

Thematic Analysis

The analysis of qualitative data can pose a challenge in any research proposal.

Siegried Kracauer argued in 1953 that:

Inadequacy of quantitative analyses stems from the methods themselves: when trying to establish the meaning of texts by breaking them down into quantifiable units (words, expression), analysts in fact destroy the very object they are supposed to be studying. (Kracauer, cited in Denzin & Lincoln, 1994, p. 359)

Kracauer advocated an approach that examined the context in its entirety. More simply, he advocated trying to find hidden meaning or themes in the text. Hence, a thematic analysis approach was used in this study.

The thematic analysis of the data also followed the recommendations of van Manen (1990) and Boysatzis (1998). van Manen (1990) recommends that the researcher conduct a thematic analysis using structures of experience as the foundational unit of understanding. According to Boysatzis (1998), there are several steps to conducting a thematic analysis. First, once the researcher has determined an incident of *structure experience* or, in Boysatzis's terminology, a *codable moment*, the researcher will develop a thematic code. This process of developing themes is further divided into three steps. First, the researcher must generate a code from the theory. Next, once the data are gathered, the researcher will review and rewrite codes and themes. This is to ensure that the codes are compatible with the raw data in terms of language and format. Finally, the researcher will determine the reliability of the codes by seeking inter-rater reliability on coding of a random selection of text by a trained colleague knowledgeable in the field.

Interviews with 15 participants concerning experiences and perceptions of motherhood comprised the data for the qualitative portion of this study. The data were analyzed based on recommendations of van Manen (1990) and Boysatzis (1998). Using Boysatzis's terminology, several codable moments arose, which led to the development of thematic codes. The coding manual (see Appendix G) was evaluated for construct validity and conceptual categories were derived from customary dictionary definitions as well as published scholarly works. The coding manual was also evaluated for inter-rater

reliability. A trained research clinician applied the coding manual to two interviews (12% of the total). The number of agreements in coding was 100%. Out of a possible seven different codes, both raters had the same 10 agreements that were abstracted from the interviews.

Self-experience and Audit Trail

Additionally, other qualitative researchers (Marshall & Rossman, 2011) recommended that prior to conducting the interview process, the researcher write a full description of his or her own experience with the phenomenon, thereby bracketing off his or her experiences from those interviewees. This phase of the inquiry is referred as epoch. The purpose of this self-examination is to permit the researcher to gain clarity from his or her own preconceptions, and it is part of the “ongoing process rather than a fixed event” (Patton, 1990, p. 408). Accordingly, I have completed the following epoch:

1. a. I am a mother of three. I have no personal experience of postpartum depression although I have experienced anxiety within the postpartum period. This anxiety was ever-present but did not necessitate treatment. Although I have never suffered from postpartum depression, I know firsthand how difficult it is to transition into the new role of becoming a mom. I am also a social worker who works with women throughout different life stages. My main focus has been with women primarily in the postpartum period. I work with women who are struggling with the transition into motherhood, women who have been diagnosed with postpartum depression and anxiety. I conduct individual interpersonal and supportive psychotherapy within a team milieu.

Some of the women that I see are just involved in individual psychotherapy with me, while others are also seeing a psychiatrist for medication treatment. I also facilitate a group at Northwestern University that is called the New Moms Support Group. This group is a six week group that women can join once they are two weeks postpartum until they are one year postpartum. It provides a forum for women to talk about their experiences as new moms. This group also allows women not to feel isolated during their transition into motherhood. Women are able to talk about their experiences in a neutral environment and gain validation that they are not the only ones experiencing what they are going through.

There were seven additional steps involved in the qualitative analysis. These steps are stated below:

1. I immersed myself in my data, and found key words and phrases in the interviews that reoccurred. These words helped to indicate how the research participants were experiencing the phenomenon. Key words and phrases that appeared in my data were coded as follows: competence, supportive mother, depression, incompetence, anxiety, loss of pleasure in parenting, and sources of support.
2. Through careful analysis of the data, I sought to capture answers to the research questions.

3. I also sought input from research assistants to control for bias and to achieve consensus on the meanings of key words and phrases. This is called inter-rater reliability.
4. Based on the concepts of interest pursued in the interviews, three categories: attachment, role shift, and social support were established.
5. Throughout the process, notes on determining the categories and codes based on understanding of the data were kept and shared with research assistants and dissertation committee to ensure analytical accuracy and to help me search for any alternative understanding which further illuminated the basic assertion of my inquiry.
6. From the coded categories and analytic memos, interpretation of the meaning of the data emerged and brought coherence and connection to the purpose of the inquiry.
7. Finally, I wrote the data analysis and discussion chapters, elucidating and applying the findings from this study.

Limitations

There are limits to the design and analysis of this study. First, the size of the sample is small and likely unrepresentative of all women experiencing difficulty in the postpartum period. Although it is sufficient for eliciting recurrent themes in qualitative research, it still is limited in its generalizability. Furthermore, the participants in this study are able to pay for the services they receive up front. They do not use their insurance to pay for the services they receive at Wellsprings since the caregivers at

Wellsprings do not accept insurance. The fact that the participants in this study are financially able to pay for the services that they receive puts them in a specific economic group that may not be consistent with other women who are experiencing difficulty in the postpartum period. This fact affects the external validity of this study; specifically, the generalizability of the information that is gathered from the population that is studied.

In order to counter challenges regarding external validity I followed the theoretical framework of Marshall and Rossman (2011) for data collection purposes. Using previously tested theoretical parameters for sufficiently similar purposes can help determine if the cases described can be generalized for new research policy (p. 202). Another limitation is the trustworthiness of the data with regard to its descriptive and theoretical validity. The data I captured are subjective, lived experiences open to the language and interpretation of the participant. The goal of this research was to find out if a reoccurring pattern of a subjective experience exists among women in the postpartum period and to apply this to clinical social work practice. Research referred to in the literature review suggests there may be patterns in women who experience difficulty in the postpartum period. In order to support the trustworthiness of the data, I captured the participants' concepts of attachment, their understanding of role shift, and their ideas of social support. According to Braud and Anderson (1998), validity can be not only a measure of objective consistency and fidelity, but also a feature that is able to convey a strong subjective impression of significance. Braud and Anderson quote John Polkinghorne, who has expertise in both mathematical physics and theology, "The test of

the validity of an exercise...will lie in its ability to discern pattern, to offer coherent understanding of human experience at its most profound” (p. 224).

Qualitative research that is based on interviews invariably uses language, but language can be studied in different ways. For instance, one can use linguistic or semiotic analysis, or use verbal self-report data to study behavior, or one can use verbal self-report data to study the subjective experiences of informants.

The data required to study experience require that they are derived from an intensive exploration with a participant. Such an exploration results in languaged data. The languaged data are not simply single words but interrelated words combined into sentences and sentences combined into discourses. The interconnections and complex relations of which discourse data are composed make it difficult to transform them into numbers for analysis. Producing findings from these data require analytic tools specifically designed to work with language data. (Polkinghorne, 2005, p. 139)

The actual accounts that the participants provided became the data for this study.

Confidentiality

All study participants obtained a consent form upon arrival for their first appointment. This form was completed before any study procedures begin. All data were held in the strictest confidence. Participants were given an ID number that was used on all subject documents, files, and databases. Names were not marked on any questionnaire materials. One master list matching respondent names and ID numbers was maintained by the private investigator in a secure file. All study records were maintained in a locked cabinet at Wellsprings Health Associates.

No harm occurred to any participants as a result of their participation in this study. During the survey or interview process, it was possible that as a mother reflected

on her experience, she may have become distressed. Participants were notified in the consent and were told that they could cease participation at any time and that the researcher would be available to debrief and provide support at any time during study participation.

CHAPTER FOUR

RESULTS

Demographics

Scales completed by 15 participants comprised the data for the quantitative portion of this study. The data were analyzed using the statistical program SPSS. The mean age of participants was 33.5. Ninety-three percent of the women were Caucasian, 6% were Asian, 50% of the women had a master's degree or higher degree, 80% of the women were still employed when they delivered, and 50% of the women who were still working at time of delivery were planning to return to work full time. The remaining women were either returning to work part time or planning to stay home. All of the new moms stated their household income fit a middle class or higher socioeconomic bracket.

Hypothesis Testing

The hypothesis tested in this study was that postpartum depression occurs when complicated early attachments have not been modified by either a sense of efficacy in one's new role as a mother or social supports existing during the time of new motherhood. This study did not confirm the hypothesis. What was revealed through this study was that previous attachment was important, but not the most important factor in preventing postpartum depression. The most important finding discovered was that perceived support by the new mother was the most protective factor during the postpartum period. Through this discovery, it is safe to say that object relations theorists

may be chagrined, because it was uncovered that present relationships are more important than past (internalized) relationships for postpartum mothers. Early attachment is important, as mothers make the transition into motherhood and develop their new roles, but can be surpassed by the protective impact of present support.

An Important Relationship Exists Between Depression and Competence

Competence and depression as illustrated by quantitative data. Looking at the distribution of scale scores for each variable for the Edinburgh Postnatal scale and the McPhee scale, both had normal distribution as demonstrated by Table 1. This is a representative sample even though it is a small population. For the Edinburgh Postnatal scale, a test of normality indicated normal distribution (Shapiro-Wilk statistic=.910, $df=11$, $p=.243$). For competence as determined by the McPhee scale, a test of normality indicated normal distribution (Shapiro-Wilk statistic=.931, $df=11$, $p=.418$). Using Pearson's correlation to analyze the EPDS and the McPhee Self-Perceptions of the Parental Role Scale, due to the linear relationship, it was revealed that there is a significant relationship between depression and competence such that the higher the depression score the lower the competence score ($R=-.737$, $p=0.015$). The p value is modest, which may be due to the limited power resulting from a small sample size. The strength of the actual correlation is considered strong according to Pearson.

Table 1. Correlations in McPhee Subscales

	Total	Investment	Competence	Integration	Satisfaction
Total	1	.567	-.737	-.592	-.234
Pearson Correlation		.087	.015	.072	.515
Sig. (2-Tailed)					
N	11	10	10	10	10

Further supporting the above findings, using Pearson's correlation to analyze the PP-QOL and competence as rated by the McPhee Scale, a significant correlation was found between competence as rated by the McPhee Scale and the feeling of "I know what to do when my baby cries" as rated by the PP-QOL scale ($R=-.686$, $p=.041$). Again, the p value was quite modest, which may be due to the limited sample size.

In 11 of the 15 interviews, the women made a significant connection between feelings of competence and depression. Competence was an important factor in whether a mother was depressed or not in each of the interviews. Even more so, competence appeared to be a strong indicator of whether or not women felt anxious during her postpartum period. Certain factors contributed to competence, including a mother's standards and her fears. If a woman placed high expectations on herself and was unable to meet her own goals, she often felt less competent. An example of high expectations that came up in several interviews was the inability to breastfeed. If a woman was not able to breastfeed, a goal that many women place on themselves, the feeling of not being

a competent mother was often experienced. Another example of a high expectation that mothers place on themselves was being able to be everything for everyone. One mother stated: “I kind of felt like I was putting my career on hold a little bit, um, so that’s probably my biggest concern—like the one thing that has bothered me about having the baby.” Many women believe that they can have it all immediately and that their new role as mommy will come as naturally as having a baby should be. Many women fail to realize that the transition takes time and new roles do not develop overnight.

Another dimension of competence had to do with a mother’s confidence in her ability to plan and predict how things would go with her baby. Feeling less competent was directly connected with feeling more depressed. Quite simply, if things did not go the way a new mother planned, her depression and anxiety increased. After all, competence is synonymous with expertise and becoming a new mom is a unique experience that does not come automatically to all women. Becoming an expert takes time.

One mother confirmed her struggle when she said:

My experience postpartum has been a lot different than I thought it was [going to be]. It’s been good and bad. Probably the good part is definitely my baby and now that he smiles at you and coos. My postpartum experience has been more stressful than I could sort of describe. I didn’t think it would be as hard as it is.

The above passage also confirms that women often expect a certain level of competence from themselves when they first are adjusting to motherhood. Women in this study continued to illustrate the fact that their expectations of themselves often did not align with their actual experiences.

Another woman touched on the issue of feeling validated, which is connected with feeling competent, when she described her experience postpartum. If a woman does not feel like she is validated, it makes it harder to build a sense of competence. According to one mother who had a six week old daughter, “It is a lot more work with a lot less reward.” Everyone needs to receive some validation in order to build their sense of self. For new moms in particular, with little or no validation, it makes it harder to build a sense of identity as a new mother. Competence is built over time; it is not something that develops instantly. Competence is built through a dialogue that is created through relationships.

A consistent example of not feeling competent was when a woman had difficulty breastfeeding or was unable to breastfeed. This is also a perfect example of how women place certain expectations on themselves of what they want in the postpartum period. Certainly all the experience in the world will not prepare a mother for what breastfeeding will be like with her individual infant. According to the Center for Disease Control, in a 2011 study, 70.6% of mothers in Illinois attempted breastfeeding; 14.3% of these women were still breastfeeding at six months. This illustrates the difficulty that breastfeeding presents and the commitment that many women cannot endure because of a multitude of reasons. Some examples of why women discontinue breastfeeding include not feeling supported, pain, going back to work, and time commitment (please see Table 2).

One mother summarized her experience when she said:

You think it’s going to be rewarding right off the bat and you’re just going to be happy all the time; for the most part it is true but you don’t realize how tired you are and how demanding it is—especially if you’re

breastfeeding—how on you have to be. You don't get any time to yourself.
You don't realize how much you don't have for yourself.

Table 2. Breastfeeding Statistics in the United States

State	Ever Breastfed	Breastfeeding at 6 months	Breastfeeding at 12 months	Exclusive breast-feeding at 3 months	Exclusive breast-feeding at 6 months
U.S. National	74.6	44.3	23.8	35.0	14.8
Alabama	56.7	24.4	8.0	19.8	5.9
Alaska	84.2	45.5	25.6	37.7	17.1
Arizona	78.4	52.0	22.3	36.1	12.3
Arkansas	63.9	34.0	16.0	29.9	13.7
California	86.6	59.1	40.0	48.1	25.7
Colorado	80.0	55.6	26.8	46.3	24.0
Connecticut	74.4	47.1	25.0	43.4	16.2
Delaware	71.8	40.7	18.2	31.6	11.4
District of Columbia	74.8	48.6	32.4	34.8	17.1
Florida	79.5	39.0	20.2	31.7	12.9
Georgia	71.6	36.7	18.5	27.1	10.1
Hawaii	85.0	52.4	31.2	42.4	20.8
Idaho	84.5	61.2	31.4	49.5	22.1
Illinois	70.6	44.5	21.7	35.3	14.3
Indiana	67.4	31.4	12.8	29.7	11.4
Iowa	78.0	51.9	28.8	37.2	17.0
Kansas	75.4	41.0	21.6	33.5	10.6
Kentucky	57.8	32.9	18.6	24.2	9.8
Louisiana	48.9	18.2	7.0	20.5	7.8
Maine	73.5	49.2	31.6	38.6	18.5
Maryland	78.5	45.2	27.0	32.0	13.1
Massachusetts	76.9	46.0	20.4	42.8	14.1
Michigan	69.3	42.9	18.2	31.3	16.3
Minnesota	82.5	50.9	24.1	45.0	15.0
Mississippi	50.3	22.4	10.5	19.2	5.7
Missouri	64.2	35.1	15.6	29.3	12.0
Montana	82.8	61.1	28.1	51.9	23.0
Nebraska	72.8	44.4	25.5	37.9	13.4
Nevada	80.1	45.6	23.8	32.6	11.5
New Hampshire	82.4	58.2	31.3	50.5	19.6
New Jersey	75.3	45.9	24.4	26.8	10.3
New Mexico	73.1	51.8	27.1	43.5	14.9
New York	78.2	47.7	27.7	32.7	13.7
North Carolina	67.3	37.0	19.6	28.1	8.2
North Dakota	71.4	46.1	23.6	41.0	18.7
Ohio	66.8	40.4	16.8	31.1	8.6
Oklahoma	67.5	36.1	17.9	29.5	11.9
Oregon	91.2	62.5	34.5	50.3	21.0
Pennsylvania	63.4	37.6	17.7	33.4	14.4
Rhode Island	70.4	38.0	19.3	33.0	12.9

South Carolina	62.5	26.5	14.5	23.0	7.1
South Dakota	69.9	44.5	24.3	38.8	15.2
Tennessee	65.6	35.5	14.8	27.9	12.8
Texas	75.2	42.2	23.0	30.6	13.5
Utah	84.5	61.5	29.3	44.1	17.0
Vermont	85.2	63.2	37.1	58.9	25.5
Virginia	79.1	40.8	22.9	36.5	14.5
Washington	89.0	60.2	35.0	49.1	23.0
West Virginia	54.1	26.2	11.9	21.7	5.6
Wisconsin	73.7	44.5	24.9	38.2	14.7
Wyoming	83.2	48.2	21.4	47.9	17.2

Note: Percentages in bold are those that have met the Healthy People 2020 objective.

Source: Centers for Disease Control and Prevention National Immunization Survey, Provisional Data, 2008 births. Retrieved from http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm

Another woman illustrated the belief that having a baby is often not what you expect. It also illuminated the fact that it is constant responsibility with little time built in for just the mother. She speaks about not feeling competent when she states:

I wouldn't say I thought it would be easier. You know you always see the cartoons with the frazzled mom and whatever. But, I did think I would be able to handle it better because of all of my experience with babysitting and, um, how much I love kids and how good I, um, am with them.

Support and Competence

The qualitative data in this study support the theory that competence increases with the support a woman feels she has. Women either clearly recognized the support as coming from a specific individual or could feel supported without knowing the exact source of support. Likewise, competence was either clearly confirmed or endorsed in the interviews. Out of 15 interviews, nine women endorsed feeling a loss of competence either implicitly or explicitly. In this study, six women who endorsed feeling less depressed confirmed feeling competent and reported having primary support from their mothers. For example, in one woman's statement, she clearly was implicitly confirming

that she felt competent in her new role as mommy: “[I am] not as anxious or overwhelmed about doing things, trying things, or as stressed.” This above quoted new mom later went on to describe her relationship with her mother: “[We are] very close. I talk to her like every day—a couple of times a day. She is very helpful, very hands on throughout. Since the baby’s birth.”

Some women endorsed feeling incompetent overtly while other women could not exactly place their finger on their feeling of not really knowing what they were doing. For example, one woman stated: “I don’t feel as good as I would want to feel.”

For a lot of the new mothers, their loss was implicitly felt and they did not exactly acknowledge that they were feeling a loss of competence, but they confirmed implicit feelings of not feeling like themselves. For example, one mother stated:

I am feeling happy about the baby. I absolutely love her, but I am feeling kind of anxious all the time and, um, doubting myself constantly. So I am not necessarily feeling sad, but I am feeling, um, kind of panicked sometimes. I feel freaked out, frustrated, not confident, um, nervous.

For a new mom who confirmed that she was feeling depressed, she stated repeatedly in her interview that: “I thought it would be a lot easier than it has been.” Her mother, who was experiencing breast cancer, although previously extremely supportive during other transitions; helping her transition into college, moving, getting married, was not able to help as much. The new mom stated: “So that’s been hard and she wasn’t able to help as much and I think she feels guilty.” The interviews in this study confirm that a woman’s relationship with her mother during her transition into motherhood is a better predictor of postpartum depression than a mother and daughter’s relationship prior to the

birth of the baby. While past support is important, the stress of motherhood is such that a woman needs help in the present no matter how much she has had in the past.

As confirmed by the McPhee scale and the findings in this study, satisfaction with social resources is a better predictor of functioning than the amount of contact with those resources. Some women in their interviews confirmed the support they felt by their mothers by giving actual examples of their mothers' help, while other mothers certainly felt the support without their mothers actually being present. For examples of implicit and explicit support as confirmed by the mothers in their own words, please see Table 3. Furthermore, mothers who are more satisfied with the support they receive are more satisfied with their parental role (McPhee, 1986). Likewise role adjustment will correlate with the self-perception of the parental role and the relationship with support systems: spouse, family, and friends.

To support McPhee's belief that satisfaction with social resources is a better predictor than the amount of resources, one woman described her feeling towards her support system:

My mom has been with us for the first two weeks, but she went home, but she's back. She will stay maybe next week and that has calmed me down a lot. Um. ...Certainly my husband and then my mom and my mother in law has offered to help but we have a nephew who is 1½ and she is a teacher, so she is not as flexible. Um, this weekend my mother in law came down—my husband had to go to a wedding. I moved to Chicago three years ago and I feel that I don't have the same friends as I did in Michigan. That's where I grew up and that's been a big change—most of my friends are from out of town. I am used to being away from people that I care about a lot, but it's tough now because my mom has to come stay with me. I don't feel isolated and, um, I think maybe part of that is because my husband and I go out a lot with each other and see our friends when we can, but most of our friends got kids. It is amazing how little we

actually see our friends. Um, but, I don't feel like it's been a big change having them back. Like it hasn't changed my social like that much. Is that what you're getting at? I certainly don't feel like I am all alone or that I have been cut off from the world.

Table 3. Perception of Support

<u>Implicitly confirmed support</u>	<u>Explicitly confirmed support and confirmation of not being supported</u>
<p>My mom has been with us for the first two weeks, but she went home, but she's back. She will stay maybe next week and that has calmed me down a lot. Um. ... Certainly my husband and then my mom and my mother in law has offered to help but we have a nephew who is 1½ and she is a teacher, so she is not as flexible. Um, this weekend my mother in law came down—my husband had to go to a wedding. I moved to Chicago three years ago and I feel that I don't have the same friends as I did in Michigan. That's where I grew up and that's been a big change—most of my friends are from out of town. I am used to being away from people that I care about a lot, but it's tough now because my mom has to come stay with me. I don't feel isolated and, um, I think maybe part of that is because my husband and I go out a lot with each other and see our friends when we can, but most of our friends got kids. It is amazing how little we actually see our friends. Um, but, I don't feel like it's been a big change having them back. Like it hasn't changed my social like that much. Is that what you're getting at? I certainly don't feel like I am all alone or that I have been cut off from the world</p>	<p>[We are] very close. I talk her like every day—a couple of times a day. She is very helpful, very hands in throughout. Since the baby's birth.</p> <p>My mother is typically a huge support in my life and I talk to her about whatever, but with her work schedule and everything lately she has not been able to provide me a lot of support.</p> <p>Very, very close, she is like my best friend. Ah yes, again, if I allowed her to she would have been more helpful.</p>

Feeling as if they have been cut off from the world, or disconnected, is something that I have often heard women describe when talking about their experience postpartum.

The above illustration, by a woman who is not depressed, highlights the fact that a new mom may not have a lot of supporters, but her perception or feeling of being supported may be present despite the actual numbers.

Probably the most influential source of support was the mother's mother. All 15 women were able to talk implicitly or explicitly about their relationships with their mothers and whether or not they felt supported. If a mother felt supported by her mother, her competence appeared to increase and her anxiety appeared to decrease.

Incompetence was also associated with a woman feeling more depressed, more anxious, and less supported by her mother. The next quote is from a woman who was feeling quite anxious and depressed. She recognizes that not having her mother's support has affected her transition into motherhood. When asked about her relationship with mother and her mother's support during her postpartum transition, this mother was able to report explicitly: "My mother is typically a huge support in my life and I talk to her about whatever, but with her work schedule and everything lately she has not been able to provide me a lot of support."

Another mother implicitly endorsed the significance of her relationship with her mother when asked about her available supports. Her mother babysat for her baby 2 days a week. She stated: "Um. I mean it's good, but I don't think she realizes the annoying things. She acts like her mother but you can't tell her because she would be horrified. Even though she means well and is supportive and is a good mother for the most part she has her faults."

Additionally, the mother's support was very important to many of these new mothers, even if the mother-daughter relationship growing up was very unsatisfactory and not recognized as significant by the new mother.

Competence and Loss

It was striking that it was exceedingly difficult to find any examples of pleasure in caregiving from the sample of women that was used in this study. The lack of pleasure (clinically termed anhedonia) seemed related in turn to feelings of lack of competence. Out of the 15 interviews, 11 women endorsed implicitly and explicitly not feeling competent. It does appear to be supported by the data in this study that depression and competence are casually related. More specifically, they are interactive. Most women do not find pleasure in things that they do not feel competent in and therefore are more likely to feel depressed. Further, the mothers seemed to be more troubled and confused by their lack of pleasure precisely because they had chosen and wanted their children. One mom, who admitted feeling depressed, spoke about her loss of control:

In terms of loss—I think it is the control. Like the environment I like stuff done in a specific way and things to be done in a specific way. I like routines. I used to make to do lists with my daughter and every day the lists would get longer and longer and nothing would get checked off. I have been experimenting—to gain control—because he is not on a schedule. I try to start his bath earlier. His schedule changes every day.

Competence and depression were not related to whether or not the baby was chosen or unplanned. All of the women in this study had chosen to become pregnant. Not knowing what they were doing was overwhelmingly present in this population and often took away from the pleasurable experience they thought they should be having

Depression and integration as illustrated by quantitative data. Although not significant, due to limited sample size, there is an additional correlation that rates towards a strong trend level. This trend indicates that the higher the depression rating score, the less integrated a new mom feels. According to McPhee, integration is similar to feeling competent; it is a synthesis of knowledge and skill (please see Figures 1 and 2).

Using the self-evaluation questionnaire there were no significant findings, again due to the limited sample size, but once again there were strong trends towards lack of competence and feeling more depressed.

Competence, Depression, and Anxiety

There also was a link between feeling a loss in confidence and depression and/or anxiety. Also a loss in self, as defined by not knowing who one is in a new role, seems to be consistent with decreased competence. Likewise, a woman who noted feeling incompetent was found to be more depressed as measured by the Edinburgh depression scale and also based on interview data than women who felt competent during the postpartum period.

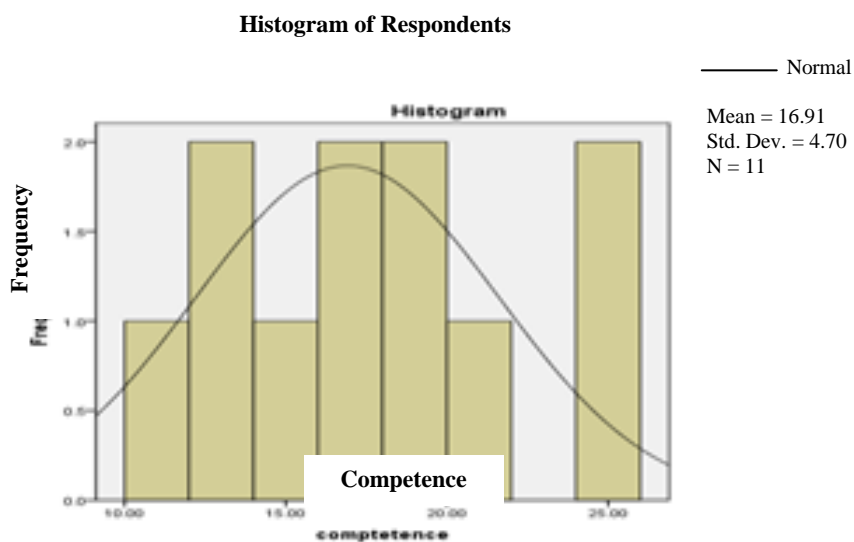


Figure 1. Rates of Depression and Feelings of Competence as determined by the McPhee scale

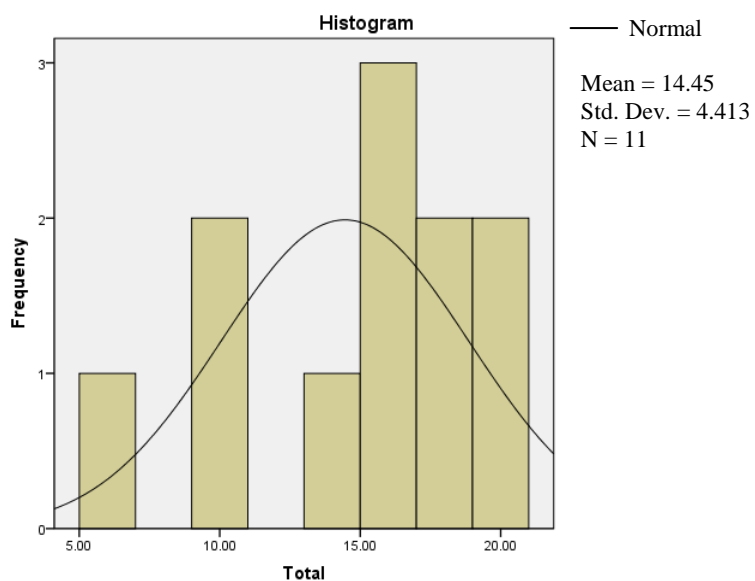


Figure 2. Rates of Depression and Feelings of Competence

CHAPTER FIVE

DISCUSSION

Postpartum depression exacts significant costs for everyone affected. Mothers are deprived of one of life's basic joys – parenting. Children are deprived of a mother's radiant enthusiasm for them and the chain of despair can be perpetuated as infants mature without a solid developmental base. Fathers or partners are often left feeling helpless and longing for the woman they knew before their wife or partner became a mother.

Postpartum depression, a depression occurring after one month postpartum and up to one year postpartum, is a well-established clinical phenomenon that presents in 10-20% of new mothers, usually occurring within six months after birth (Vasa, 2006). It has been most identified between the first and fourth months postpartum. Postpartum depression has a 5% suicide rate (O'Hara, Neunaber, & Zekoski, 1984). However, the prevalence of postpartum depression is probably even greater than the statistics indicate because many women will not seek help or become part of a database. So the 10-20% of women with confirmed diagnosis of postpartum depression probably only accounts for some of the women who are actually experiencing depression or anxiety in the postpartum period. This study confirmed that postpartum women in our culture are isolated and often do not have a place to voice their experiences. There has not been room for women to tell their story. For many women, seeking help, despite financial resources, does not become an option, as women try to fit into the role of being a new mom based on false perceptions

and pressure to be the best. These new moms are on their own without support and without a voice. Further, stigma attached to not feeling pleasure in mothering can be significant in many cultures and aggravate the guilt accompanying depression and women's isolation from help. For many women, the postpartum period certainly turns out to be as the title of the postpartum book by Kleinman and Raskin (1994) appropriately states: *This Isn't What I Expected*. We need to ask women, what did you expect? What could make this period better?

It has been established that there is a relationship between maternal role attainment and postpartum depression. In Fowles's (1998) research, postpartum depression demonstrated a significant, negative relationship to all measures of role attainment. From a theoretical perspective in social work, this study found that in order to complete a shift in role, from independent woman to a mother who is depended on, supportive relationships should exist in order to lessen the occurrence of postpartum depression. This study highlighted the fact that relationships for the mother, in particular the relationship with her own mother, are crucial mitigating factors in protecting women against postpartum depression. Furthermore, the relationships appear to help the women literally to voice their experiences. Therefore, this study, using the strengths perspective approach, adds to the current literature.

The strengths perspective emphasizes the individuals' capacities, talents, competencies, possibilities, visions and hopes. Key concepts include empowerment, resilience and membership to a viable group or community. Important sources of strength are cultural and personal stories, narratives and lore. An individual's or group's response to traumatic situations are determined by risk, "protective" and "generative" factors, which are influenced by membership to a particular community.

Emotions, beliefs, health realization and community empowerment play important roles in maintaining health and wellness. (Saleebey, 1996, p. 155)

The strengths perspective does not just emphasize strength, what is positive, it emphasizes the need to tell a story and have that story heard. The strengths perspective conceptualizes resilience to postpartum depression and competence in relational terms. The experiences that a mother has in her own relationships separate from her infant create social support and more specifically validation. The more confirmation that a woman has as she transitions into becoming a mother, the easier time she has with her role change. Support, as measured in this study, appeared to help tailor the mothers' expectations in their role as new mothers.

Furthermore, the strengths perspective along with positive psychology recognizes that depression is not just the presence of something negative or some psychopathology; it is the experienced absence of something. This study was a confirmation of the importance of women individually sharing their experiences of loss despite the type of attachments they experienced earlier in their development. This study also illuminates the fact that support through attachment is forever ongoing due to the fact that these new mothers are experiencing another developmental shift as their role changes from individual to mother.

These findings also reflect a feminist empowerment model in social work by further confirming that postpartum depression is not just a biological issue. The assumptions underlying the concept of empowerment are in sharp contrast with problem-centered medical and therapeutic paradigms that are used to viewing the individual

through a lens of deficiency (Morell, 2003, p. 69). In fact, it is hard to label a new mother deficient as she struggles with her new additional role. Feeling deficient, synonymous with incomplete, does not properly encapsulate this period. What does summarize this transition is the shared experiences that the women slowly unearth. This study highlights the need to listen to women as they describe their experiences and are empowered by doing so. Postpartum depression needs to be understood as it is being experienced by women and can only be recognized when it is given a voice.

Contemporary approaches to postpartum depression tend to focus primarily on individual neurochemical processes, such as shifts in thyroid function following the birth of the baby, and secondarily on social supports. The findings presented here indicate that the relationship between depression, competence, and social support is powerful and deserves increased examination. This is not to say that the biological factors are not significant and not indicative of postpartum depression; but competence and lack of competence however, cannot be measured through blood and need to be measured through the dialogue that must begin for women who are struggling with depression and anxiety in the postpartum period.

The Importance of Relating Postpartum Depression and Competence

Postpartum depression has been widely studied, but as it relates to maternal competence continues not to be fully understood. In a Taiwanese study conducted in 2008 (Chu, 2008), correlations were found between postpartum depressive symptoms and feelings of support and between feelings of support and maternal competence, although they were not strong. This study confirms a strong correlation, despite a limited sample

size, and provides confirmation of how interactive the relationships are between depression, social support, and competence.

The mean age of the women in this study, 33.5, may help to illustrate why such a correlation has appeared. Women who are already established professionally are accustomed to feeling secure, confident, and having a sense of predictability in their lives: in a word, they are competent. They have come to a point in their lives where they have achieved certainty. Having a baby creates a world that many women worked to avoid, a world of feeling uncertain. Feeling competent is often a loss that women describe when they are asked about losses they have experienced in the postpartum period. One of the ways that women increase their competence is by becoming educated in the area that they feel uncertain. When asked about her experience, one mother confirmed:

I think having children is probably one of the best things I have ever done, but I think it is also the hardest. I think people need to be educated more about what it means to be a parent.

The above quote also speaks to the idea of isolation and the fact that women do not know that what they are feeling is normal and not indicative of doing a poor job as a new mother.

This study illuminates the value of studying subjective experiences in order to understand interactive causality more deeply. I want to change the protocol for treating postpartum depression that focuses on a symptom from an epidemiological standpoint and encourage understanding the dynamics of the process of postpartum depression as the women themselves experience and report it. Perhaps a new model could be established

that helps to predict women's susceptibility to developing postpartum depression that focuses on perceptions of the experience of the transition into motherhood.

Implications for Social Policies

Compared to other industrialized nations, the United States falls far short of the support for mothers that is part of national policy in other countries. Still, women are under pressure in our society to provide all that is needed to a new baby. Cultural pressures, pressure to breastfeed, and the invisibility that women experience in the work of nurturing can result in a breeding ground for postpartum depression in the weeks, months, and year following the birth of a baby, whether it is a first baby or a subsequent childbirth. There is no increase in the incidence of postpartum depression for first-time mothers over other women who already have a child or children, and vice versa.

This study, in quantifiably and qualitatively asking postpartum women about their experiences since having a baby, seeks to understanding a woman's perception of her new role, among other things. It was in fact confirmed that the more difficulty a woman had in identifying her new role, specifically in perceiving that she was competent, the higher the likelihood of depression in the postpartum period. This illustrates another point: women's perceptions of competence may not be a true reflection of how competent they actually are in taking care of their babies.

Implications for Clinical Social Work Practice

How do we help women to increase their competence and simultaneously increase the pleasure that can be found through motherhood? The fact that support groups have been found to be successful in helping women to feel less depressed during the

postpartum period is an illustration that learning by being exposed to other women's experiences may help new moms to feel more competent. This study did not confirm that support was correlated with depression; it was only the perception of competence.

Groups also provide a secondary benefit besides educating a new mom about taking care of her newborn. Being amongst moms who have babies of similar ages may provide some moms with the feeling that they have mastered a skill or struggle, such as feeding and sleep, when other mothers still question themselves. Hearing about other women's struggles may help another mom feel more competent in what she has already mastered.

Also, providing postpartum groups as part of the hospital experience for women may aid in the transition into motherhood for mothers and may even spearhead against depression for new moms. This is similar to an orientation period during college.

Students who enter into college often are required to have an orientation period, rather than just beginning their college experience. The communal experience of going through something new helps with students' transitions. Often classes are offered to women who are pregnant about anticipated infant care and breastfeeding, but the real support appears to be needed after the baby is born, because what support is needed is not identified until the baby arrives. Women also report that they feel like they should know what they are doing, although they feel at a total loss. Additionally, just like planning for labor, there is no way to predict how things are going to feel once the baby arrives. If a new mom could be around other new moms who are feeling the same way, some of their fears and feeling of incompetence could be buffered.

Implications for Policies Supporting Mothers and Preventing and Treating Postpartum Depression

Currently in our culture, Chicago to be specific, the treatment and more specifically the identification of postpartum depression is quite limited. For example, during a mother's six-week check up with her physician, it is the practice that a new mother receives an Edinburgh scale. This is the only measurement for postpartum depression that is given. Most physicians allow approximately 20 minutes for the six-week visit, which does not allow a lot of room to elaborate on how a new mom is feeling. Often there is simply not enough time during the visit for the new mom to express her anxiety or depression. There needs to be more room for women to discuss their experiences so that they can receive the help and support they need, even if they do not realize the support is missing. Considering the isolation that women feel during this period, the six week visit provides a real opportunity for women to express their feelings and simply describe what they are experiencing.

Implications for Research

Future studies may benefit the postpartum population in the examination of how to build a sense of competence for women before their baby arrives. There needs to be more of a focus on building psychoeducational programs for women in order to guide them through the postpartum period, rather than "preparing" them for the postpartum period. After all, as this study illustrates, each woman's experience is different. A program that can guide and help gain confidence through the elimination of isolation is better equipped at safeguarding against postpartum depression. We need to build

communities that create discussions for new mothers. Finally, one mother supported the need for groups perfectly when she stated:

I guess what my issue is, is that I don't know where relative to where I am supposed to be—Am I supposed to be perfect? So that I think that I am fine. Like when I go to that group, I see that I am not that bad. But, um, I don't feel as good as I would want to feel.

CHAPTER SIX

CONCLUSION

This study addressed the following research questions: Does complicated attachment, as reported by mothers with postpartum depression, correlate with greater difficulty in the postpartum period? Is there a correlation between the difficulty a woman has in identifying her role as a new mother and the likelihood of depression in the postpartum period? Are women who perceive a higher level of social support less likely to report feeling depressed? How do the mothers experience the interaction of these variables with each other? Specifically, the hypothesis was that postpartum depression occurs when complicated early attachments have not been modified by either a sense of efficacy in one's new role as a mother or social supports existing during the time of new motherhood.

Complicated attachment, as reported by mothers with postpartum depression, did not correlate with greater difficulty in the postpartum period. Despite the type of attachment that a new mother had during her development, current relationships were the most influential in decreasing experiences of depression and anxiety, not early relationships. The relationship that a new mother had with her mother in particular, despite early conflict, appeared to be the most important relationship, even more so than the relationship with her spouse, for a mother during her early transition into motherhood as reported in the interviews.

For new mothers, there was a correlation between the difficulty a woman had in identifying her role as a new mother and the chance of depression in the postpartum period as far as competence was concerned. It was revealed that there is a significant relationship between depression and competence such that the higher the depression score, the lower the competence score ($R=-.737$, $p=.015$). Additionally, using Pearson's correlation to analyze the PP-QOL scale and competence as rated by the McPhee scale, a significant correlation was found between competence as rated by the McPhee Scale and the feeling of "I know what to do when my baby cries" as rated by the PP-QOL scale ($R=-.686$, $p=.041$).

Women who perceived a higher level of social support were less likely to report feeling depressed. Once again, having the support of their mothers lessened the experience of depression and/or anxiety. The support of a mother's mother was identified throughout the interviews both implicitly and explicitly.

This was a mixed methods study. Variables examined in this study included attachment, role shift, social support, and postpartum depression. Study participants completed four self-report scales and participated in a brief interview. First, postpartum depression was measured by the EPDS. Second, social support was measured by the PP-QOL Measure. Third, role identity was measured by the MAQ. Finally, the McPhee Scale measured attachment. In addition to the scales, the qualitative portion of this study included an interview which asked women about their experiences postpartum in addition to what they thought mothering would be like.

Due to the limited sample size, 15, there were few significant findings in the quantitative portion. Primarily, the correlation between depression and competence was confirmed using Pearson's correlation in the Edinburgh and McPhee Scale and the McPhee Scale and PP-QOL. There were, however, many significant trends. These trends included correlations between Edinburgh scores and investment as determined by the McPhee scale, Edinburgh scores and integration as determined by the McPhee Scale, and Edinburgh scores and satisfaction as determined by the McPhee Scale.

The most significant findings were obtained in the interviews. As the new mothers spoke, their perceptions of their support systems and lack thereof were able truly to come to life. For example, some women were able to see clearly the significance of the support they received from their mothers while other women, who clearly received support, were unaware of the source of support or its significance. Whether a woman perceives support or not, there is no question that support is significant in the mitigation of postpartum depression. This highlights the need for further dialogue about a woman's experience postpartum. This dialogue further supports the strengths perspective. Additionally, the field of postpartum depression could be enriched by research that examines women's perception of support.

The perspective applied in this dissertation assumed that the women's points of view can provide valuable scientific information about postpartum depression. Often we can recognize the symptoms, but one cannot adequately provide effective psychotherapy when focusing on symptoms alone. We need to continue to listen to women, to hear their experiences, and to validate their perspectives and strengths, not just to treat their

symptoms. We can learn about this condition that is so problematic for so many families by hearing a woman's individual experience. By incorporating new mothers' experiences, we will have better foundations for scientific theories about postpartum depression and for practices and policies to benefit women and families. As we have discovered in this research, the symptom of depression is just the tip of the iceberg, whereas the isolation and lack of competence that a woman feels, could be the prolonged effect that needs to be addressed.

By using a strengths perspective, we need to hear women's stories as we try to understand their perceptions of their unique experiences. This is a unique spin on postpartum depression, as it addresses the individual's experience rather than a cluster of symptoms. This is postpartum depression as studied through a social work lens.

APPENDIX A

EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS)

Edinburgh Postnatal Depression Scale

Please circle the answer that best describes how you have felt over the past 7 days.

1. I have been able to laugh and see the funny side of things:
 - 0 As much as I always could
 - 1 Not quite so much now
 - 2 Definitely not quite so much now
 - 3 Not at all
2. I have looked forward with enjoyment to things:
 - 0 As much as I ever did
 - 1 Somewhat less than I used to
 - 2 A lot less than I used to
 - 3 Hardly at all
3. I have blamed myself unnecessarily when things went wrong:
 - 3 Yes, most of the time
 - 2 Yes some of the time
 - 1 Not very often
 - 0 No, never
4. I have felt worried and anxious for no good reason:
 - 0 No, hardly at all
 - 1 Hardly ever
 - 2 Yes, sometimes
 - 3 Yes, very often
5. I have felt scared or panicky for no good reason:
 - 3 Yes, quite a lot
 - 2 Yes, sometimes
 - 1 No, not much
 - 0 No, not at all
6. Things have been too much for me:
 - 3 Yes, most of the time I haven't been able to cope at all
 - 2 Yes, sometimes I haven't been coping as well as usual
 - 1 No, most of the time I have coped quite well
 - 0 No, I have been coping as well as ever
7. I have been so unhappy that I have had difficulty sleeping:
 - 3 Yes, most of the time
 - 2 Yes, sometimes
 - 1 Not very often
 - 0 No, not at all
8. I have felt sad or miserable:
 - 3 Yes, most of the time
 - 2 Yes, quite often
 - 1 Not very often
 - 0 No, not at all
9. I have been so unhappy that I have been crying:
 - 3 Yes, most of the time
 - 2 Yes, quite often
 - 1 Only occasionally
 - 0 No, never
10. The thought of harming myself has occurred to me:
 - 3 Yes, quite often
 - 2 Sometimes
 - 1 Hardly ever
 - 0 Never

(From Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. Br J Psychiatry 1987; 150: 782-786.)

Name: _____

Date: _____

Score: _____

APPENDIX B

POSTPARTUM QUALITY OF LIFE QUESTIONNAIRE (PP-QOL)

Subject ID _____

Postpartum quality of life questionnaire - PPQOL

Below is a list of statements that other postpartum women have said are important. By choosing one (1) number per line, please indicate how true each statement has been for you during the past 7 days.

		No at all	A little bit	Some what	Quite a bit	Very much
1	I feel sad	0	1	2	3	4
2	I feel overwhelmed	0	1	2	3	4
3	I cope well with ups & downs	0	1	2	3	4
4	I miss the way my life was before the baby	0	1	2	3	4
5	This was a good time in my life to have the baby	0	1	2	3	4
6	I wish I had more time for work outside or inside my home	0	1	2	3	4
7	I miss my independence	0	1	2	3	4
8	I am able to enjoy life	0	1	2	3	4
9	I am content with the quality of my life right now	0	1	2	3	4
10	I'm glad I had this baby	0	1	2	3	4
11	Having a baby has enriched my life	0	1	2	3	4
12	I like how much my baby needs me	0	1	2	3	4
13	I enjoy being a mother	0	1	2	3	4
14	I am happy with my child care situation	0	1	2	3	4
15	Being with the baby is boring	0	1	2	3	4
16	I know what to do when my baby cries	0	1	2	3	4
17	My baby is easy to soothe	0	1	2	3	4
18	I get support from my friends	0	1	2	3	4
19	I get support from my family	0	1	2	3	4
20	I get support from my partner	0	1	2	3	4
21	My partner helps with the baby	0	1	2	3	4
22	I am bothered by vaginal bleeding	0	1	2	3	4
23	I have abdominal pain	0	1	2	3	4
24	I have pain near my vagina	0	1	2	3	4
25	I have trouble controlling my urine	0	1	2	3	4
26	I have trouble controlling my bowels	0	1	2	3	4
27	I am bothered by hemorrhoids	0	1	2	3	4
28	I am embarrassed by the change in my body's appearance	0	1	2	3	4
29	I am sleeping well	0	1	2	3	4
30	I struggle to balance work and home	0	1	2	3	4
31	I feel like I spend enough time with the baby	0	1	2	3	4
32	I have a lack of energy	0	1	2	3	4
33	I get enough time for myself	0	1	2	3	4
34	Having the baby has caused money problems	0	1	2	3	4
35	I worry about the possibility of being hit, slapped, kicked, or physically hurt by someone	0	1	2	3	4
36	I worry about the possibility of my child being hit, slapped, kicked, or physically hurt by someone	0	1	2	3	4

Subject ID _____

Are you sexually active? (If no, proceed to question #42)0 - No
1 - Yes

	0	1	2	3	4
37 I am satisfied with my sex life	0	1	2	3	4
38 Sex is physically uncomfortable	0	1	2	3	4
39 I am interested in having sex	0	1	2	3	4
40 I am afraid to have sex	0	1	2	3	4
41 I am happy with my current method of birth control	0	1	2	3	4

Are you breastfeeding? (If no, proceed to question #46)0 - No
1 - Yes

	0	1	2	3	4
42 My breasts are sore	0	1	2	3	4
43 I am having difficulty with breastfeeding	0	1	2	3	4
44 I enjoy breastfeeding	0	1	2	3	4
45 Breastfeeding makes me feel closer to my baby	0	1	2	3	4

46. Did you enjoy being pregnant?

0 - No
1 - Yes

47. Did you feel prepared for childbirth?

0 - No
1 - Yes

48. On average, how many hours of sleep do you get per day? _____

49. Is this enough for you?

0 - No
1 - Yes

APPENDIX C
MATERNAL ATTITUDES QUESTIONNAIRES

ID # _____

Date _____

Maternal Attitudes Questionnaire – Revised – Postpartum (MAQ-R-PP)

Below is a series of statements about being a mother. In each case please circle the answer which most applies to you. This questionnaire is seeking your opinion – there are no right or wrong answers.

-
1. I think my baby is very demanding.
Strongly Agree *Agree* *Disagree* *Strongly Disagree*
2. I feel proud of being a mother.
Strongly Agree *Agree* *Disagree* *Strongly Disagree*
3. I am disappointed by motherhood.
Strongly Agree *Agree* *Disagree* *Strongly Disagree*
4. Having a baby has made me as happy as I expected.
Strongly Agree *Agree* *Disagree* *Strongly Disagree*
5. I sometimes regret having a baby.
Strongly Agree *Agree* *Disagree* *Strongly Disagree*
6. I am the only person who can look after my baby properly.
Strongly Agree *Agree* *Disagree* *Strongly Disagree*
7. To be a good mother, I should be able to cope well all the time.
Strongly Agree *Agree* *Disagree* *Strongly Disagree*
8. If my baby is unwell or unhappy it is not my fault.
Strongly Agree *Agree* *Disagree* *Strongly Disagree*
9. I have resented not having enough time to myself since having my baby.
Strongly Agree *Agree* *Disagree* *Strongly Disagree*
10. My daily life has been no more difficult since my baby was born.
Strongly Agree *Agree* *Disagree* *Strongly Disagree*
11. If I find being a mother difficult, I feel a failure.
Strongly Agree *Agree* *Disagree* *Strongly Disagree*
12. If I love my baby I should want to be with him/her all the time.
Strongly Agree *Agree* *Disagree* *Strongly Disagree*

13. If other people help me look after my baby, I feel a failure.
Strongly Agree *Agree* *Disagree* *Strongly Disagree*
14. I resent the way my life has been restricted since having my baby.
Strongly Agree *Agree* *Disagree* *Strongly Disagree*
15. I believe that when I was growing up, my mother was happy about being a mother.
Strongly Agree *Agree* *Disagree* *Strongly Disagree*
16. At the present time my relationship with my partner (husband or significant other) is usually:
Excellent *Good* *Fair* *Poor* *NA – No partner at this time*
17. If I need help, I can count on: (Circle most applicable response for each person listed below)
- | | | | | | |
|------------------|-----------------------|--------------|-----------------|-----------------------|-----------|
| my mother | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Agree</i> | <i>NA</i> |
| my father | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Agree</i> | <i>NA</i> |
| my partner | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Agree</i> | <i>NA</i> |
| another relative | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Agree</i> | <i>NA</i> |
| another person | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Agree</i> | <i>NA</i> |
18. If I need advice, I can count on: (Circle most applicable response for each person listed below)
- | | | | | | |
|------------------|-----------------------|--------------|-----------------|-----------------------|-----------|
| my mother | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Agree</i> | <i>NA</i> |
| my father | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Agree</i> | <i>NA</i> |
| my partner | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Agree</i> | <i>NA</i> |
| another relative | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Agree</i> | <i>NA</i> |
| another person | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Agree</i> | <i>NA</i> |

ID # _____

Date _____

Maternal Attitudes Questionnaire – Revised – Pregnancy (MAQ-R-P)

Below is a series of statements about pregnancy and being a mother. In each case please circle the answer which most applies to you. This questionnaire is seeking your opinion - there are no right or wrong answers.

1. I think pregnancy is very demanding.
Strongly Agree Agree Disagree Strongly Disagree
2. I anticipate that my baby will be very demanding.
Strongly Agree Agree Disagree Strongly Disagree
3. I feel proud of being pregnant.
Strongly Agree Agree Disagree Strongly Disagree
4. I anticipate feeling proud of being a mother.
Strongly Agree Agree Disagree Strongly Disagree
5. Being pregnant has made me as happy as I expected.
Strongly Agree Agree Disagree Strongly Disagree
6. I expect that having a baby will make me very happy.
Strongly Agree Agree Disagree Strongly Disagree
7. I sometimes regret getting pregnant.
Strongly Agree Agree Disagree Strongly Disagree
8. I am the only person who will be able to look after my baby properly.
Strongly Agree Agree Disagree Strongly Disagree
9. To be a good mother, I should be able to cope well all the time.
Strongly Agree Agree Disagree Strongly Disagree
10. If there are complications with my pregnancy it is not my fault.
Strongly Agree Agree Disagree Strongly Disagree
11. If my baby is unwell or unhappy it is not my fault.
Strongly Agree Agree Disagree Strongly Disagree
12. I have resented not having enough time to myself since becoming pregnant.
Strongly Agree Agree Disagree Strongly Disagree

13. I anticipate that I may not have enough time to myself once my baby is born.
Strongly Agree *Agree* *Disagree* *Strongly Disagree*
14. My daily life has been no more difficult since becoming pregnant.
Strongly Agree *Agree* *Disagree* *Strongly Disagree*
15. I anticipate that my daily life will be no more difficult once my baby is born.
Strongly Agree *Agree* *Disagree* *Strongly Disagree*
16. If I find being a mother difficult, I will feel a failure.
Strongly Agree *Agree* *Disagree* *Strongly Disagree*
17. If I love my baby I should want to be with him/her all the time.
Strongly Agree *Agree* *Disagree* *Strongly Disagree*
18. If other people help me look after my baby, I will feel a failure.
Strongly Agree *Agree* *Disagree* *Strongly Disagree*
19. I resent the way my life has been restricted since becoming pregnant.
Strongly Agree *Agree* *Disagree* *Strongly Disagree*
20. I believe that when I was growing up, my mother was happy about being a mother.
Strongly Agree *Agree* *Disagree* *Strongly Disagree*
21. At the present time my relationship with my partner (husband or significant other) is usually:
Excellent *Good* *Fair* *Poor* *NA – No partner at this time*
22. If I need help, I can count on: (Circle most applicable response for each person listed below)
- | | | | | | |
|------------------|-----------------------|--------------|-----------------|-----------------------|-----------|
| my mother | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Agree</i> | <i>NA</i> |
| my father | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Agree</i> | <i>NA</i> |
| my partner | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Agree</i> | <i>NA</i> |
| another relative | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Agree</i> | <i>NA</i> |
| another person | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Agree</i> | <i>NA</i> |
23. If I need advice, I can count on: (Circle most applicable response for each person listed below)
- | | | | | | |
|------------------|-----------------------|--------------|-----------------|-----------------------|-----------|
| my mother | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Agree</i> | <i>NA</i> |
| my father | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Agree</i> | <i>NA</i> |
| my partner | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Agree</i> | <i>NA</i> |
| another relative | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Agree</i> | <i>NA</i> |
| another person | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Agree</i> | <i>NA</i> |

APPENDIX D
MCPHEE SCALE

SELF-PERCEPTIONS OF THE PARENTAL ROLE

David MacPhee, Janette B Benson, and Daniel Bullock

INSTRUCTIONS

The following questions ask about how you see yourself as a parent. There are no right or wrong answers. Instead, we are interested in your opinions about the parental role and how you are doing as a parent. Please put a checkmark in only 1 of the 4 boxes for each question. Check the one that *best* describes you. For example, if you kind of like spinach, you would check the one box as shown below:

Really True for Me	Sort of True for Me			Sort of True for Me	Really True for Me	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Some people like spinach.	BUT	Other people don't like spinach.	<input type="checkbox"/>	<input type="checkbox"/>

REMEMBER: Check only *one* box per question.

1.	<input type="checkbox"/>	<input type="checkbox"/>	Some parents do a lot of reading about how to be a good parent.	BUT	Other parents don't spend much time reading about parenting.	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	Some parents have clear ideas about the right and wrong ways to rear children.	BUT	Other parents have doubts about the way they are bringing up their children.	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	Some parents feel that they don't see enough of their friends since they've had children.	BUT	Other parents see their old friends just as often, or they have made new ones.	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	Some parents often wish they hadn't had children.	BUT	Other parents rarely regret having had children.	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	Some parents want to learn everything possible about being a parent.	BUT	Other parents feel that they already know all they need to know about parenting.	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	Some parents often can't figure out what their children need or want.	BUT	Other parents seem to have a knack for understanding what their children need or want.	<input type="checkbox"/>	<input type="checkbox"/>

	Really True for Me	Sort of True for Me			Sort of True for Me	Really True for Me	
7.	<input type="checkbox"/>	<input type="checkbox"/>	Some people feel they end up making too many sacrifices for their children.	BUT	For other parents, there are more rewards than sacrifices in rearing children.	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	Some adults are more content being a parent than they ever thought possible.	BUT	For other adults, being a parent hasn't fulfilled them like they had hoped it would.	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	Some parents don't think too much about how to parent; they just do it.	BUT	Other parents try to learn as much as they can about how to parent.	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	Some parents feel that they are doing a good job of providing for their children's needs.	BUT	Other parents have doubts about how well they are meeting their children's needs.	<input type="checkbox"/>	<input type="checkbox"/>
11.	<input type="checkbox"/>	<input type="checkbox"/>	Some parents resent the fact that having children means less time to do the things they like.	BUT	Other parents don't mind having less free time for themselves.	<input type="checkbox"/>	<input type="checkbox"/>
12.	<input type="checkbox"/>	<input type="checkbox"/>	Some adults would hesitate to have children if they had it to do over again.	BUT	Given the choice, other adults wouldn't think twice before having children.	<input type="checkbox"/>	<input type="checkbox"/>
13.	<input type="checkbox"/>	<input type="checkbox"/>	Some parents feel it's a must to keep up with the latest childrearing advice and methods.	BUT	Other parents would rather deal with their children on a day-to-day basis with what they already know.	<input type="checkbox"/>	<input type="checkbox"/>
14.	<input type="checkbox"/>	<input type="checkbox"/>	Some parents often worry about how they're doing as a parent.	BUT	Other parents feel confident about their parenting abilities.	<input type="checkbox"/>	<input type="checkbox"/>
15.	<input type="checkbox"/>	<input type="checkbox"/>	For some mothers and fathers, the marriage is just as strong after having children as before.	BUT	For other mothers and fathers, being a parent gets in the way of being a good wife or husband.	<input type="checkbox"/>	<input type="checkbox"/>
16.	<input type="checkbox"/>	<input type="checkbox"/>	For some parents, children mostly feel like a burden.	BUT	For other parents, their children are a main source of joy in their lives.	<input type="checkbox"/>	<input type="checkbox"/>

	Really True for Me	Sort of True for Me			Sort of True for Me	Really True for Me	
17.	<input type="checkbox"/>	<input type="checkbox"/>	Some parents are concerned about the parental role; they think or worry about it a lot.	BUT	Other parents usually don't fret about being a parent; they take it more as a matter of course.	<input type="checkbox"/>	<input type="checkbox"/>
18.	<input type="checkbox"/>	<input type="checkbox"/>	Some mothers and fathers think that they are not very effective parents.	BUT	Other mothers and fathers think they are pretty capable as parents.	<input type="checkbox"/>	<input type="checkbox"/>
19.	<input type="checkbox"/>	<input type="checkbox"/>	For some parents, having children means that they can't do the things they used to like to do.	BUT	For other parents, having a child doesn't change their lifestyle very much.	<input type="checkbox"/>	<input type="checkbox"/>
20.	<input type="checkbox"/>	<input type="checkbox"/>	Being a parent is a satisfying experience to some adults.	BUT	For other adults, being a parent is not all that satisfying.	<input type="checkbox"/>	<input type="checkbox"/>
21.	<input type="checkbox"/>	<input type="checkbox"/>	Some mothers and fathers aren't sure they were suited to be parents.	BUT	Parenting comes easily and naturally to other parents.	<input type="checkbox"/>	<input type="checkbox"/>
22.	<input type="checkbox"/>	<input type="checkbox"/>	Some parents feel that their lives are restricted or confined since having children.	BUT	Other parents don't stop doing things they like to do just because of their children.	<input type="checkbox"/>	<input type="checkbox"/>

COMMENTS:

COMMENTS:

APPENDIX E
SELF-EVALUATION QUESTIONNAIRES

SELF-EVALUATION QUESTIONNAIRE

STAI Form Y-2

Name _____ Date _____

DIRECTIONS

A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate number to the right of the statement to indicate how you *generally* feel.

- | | | ALMOST NEVER | SOMETIMES | OFTEN | ALMOST ALWAYS |
|--|---|--------------|-----------|-------|---------------|
| 21. I feel pleasant | 1 | 2 | 3 | 4 | |
| 22. I feel nervous and restless | 1 | 2 | 3 | 4 | |
| 23. I feel satisfied with myself | 1 | 2 | 3 | 4 | |
| 24. I wish I could be as happy as others seem to be..... | 1 | 2 | 3 | 4 | |
| 25. I feel like a failure | 1 | 2 | 3 | 4 | |
| 26. I feel rested | 1 | 2 | 3 | 4 | |
| 27. I am "calm, cool, and collected" | 1 | 2 | 3 | 4 | |
| 28. I feel that difficulties are piling up so that I cannot overcome them | 1 | 2 | 3 | 4 | |
| 29. I worry too much over something that really doesn't matter..... | 1 | 2 | 3 | 4 | |
| 30. I am happy..... | 1 | 2 | 3 | 4 | |
| 31. I have disturbing thoughts..... | 1 | 2 | 3 | 4 | |
| 32. I lack self-confidence | 1 | 2 | 3 | 4 | |
| 33. I feel secure | 1 | 2 | 3 | 4 | |
| 34. I make decisions easily..... | 1 | 2 | 3 | 4 | |
| 35. I feel inadequate | 1 | 2 | 3 | 4 | |
| 36. I am content..... | 1 | 2 | 3 | 4 | |
| 37. Some unimportant thought runs through my mind and bothers me..... | 1 | 2 | 3 | 4 | |
| 38. I take disappointments so keenly that I can't put them out of my mind..... | 1 | 2 | 3 | 4 | |
| 39. I am a steady person | 1 | 2 | 3 | 4 | |
| 40. I get in a state of tension or turmoil as I think over my recent concerns and interests..... | 1 | 2 | 3 | 4 | |

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 © Copyright 1983 by Consulting Psychologists Press, Inc. All rights reserved. STAIE-AD Scoring Key

APPENDIX F
QUESTIONS

1. Please describe your experience now that you are postpartum? What has your experience been like so far?
2. Depression is defined as feeling down or depressed most of the day. You may also have some or most of these symptoms: anxiety, changes in appetite, changes in sleep, physical pain, feeling of hopelessness, worthlessness. Do you/did you feel depressed? If a participant confirms that they feel or felt depressed I would add: Please tell me more about the depression and what do you think has contributed to your depression. What has helped your depression?
3. Do you feel that people accept you for who you are? Tell me how this has helped you during this transition into motherhood.
4. Please tell me about the role that social support has played for you in becoming a mom. What has comprised your social support?
5. How has social support helped you? How has it made things harder if at all?
6. Please tell me about the role that social support has played for you in becoming a mom.
7. What did you think mothering would be like?
8. What is your relationship like with your mother?
9. Many women describe a lot of gains during this period. What are some of the gains you have experienced?
10. It is also a period of loss, what are some losses that you have experienced during this period? Has the support of others helped you? If so, how?

11. Is there anything else that you think is important for me to know that I haven't asked about?

APPENDIX G
CODING MANUAL

Coding Manual

- I. Words that reflect competence:** According to a 1986 conference paper written by McPhee, which was given at the International Conference on Infant Studies in Los Angeles, it is evident that a mother's feelings of competence as a parent are directly related to her ability to manage interactions with her children (McPhee, 1986). This is consistent with the standard definition of competence, which is the ability to feel qualified in a certain area.

Words were abstracted from the following questions that were posed to participants:

- a. Please describe your experience now that you are postpartum.
- b. Have you felt or do you feel depressed now that you are postpartum?
- c. What are some of the losses that you have experienced during this period?
- d. What did you think mothering would be like?
- e. Is there anything else I should know?

Variable name=competence.

1. EC1LN2-3 I am less stressed about him dying and things I freaked out about the first time around.
2. EC1LN2-3 I think I enjoy him so much more because I didn't know what I was doing with my daughter.
3. EC1LN9 I am not constantly anxious.
4. LB2LN1-2 Not as anxious or overwhelmed about doing things, trying new things or stressed.
5. SA4LN1-2 I am feeling kind of anxious all the time and, um, doubting myself constantly so I am feeling like questioning myself.
6. SA4LN3-4 I am not necessarily feeling sad, but I am feeling kind of panicked sometimes. I feel freaked out—frustrated, not confident, um nervous.
7. SA4LN 13-14 Um, I guess what I have lost is my, um, right now it feels like I have lost my old professional self, my professional confidence, and my own ability to speak and think clearly.
8. KH5LN7 Knots in my stomach.
9. KH5LN11 More overwhelming.
10. HHLN3-4 um, my postpartum.

- II. Words that reflect having a supportive mother:** According to one dictionary definition, support is defined as “to hold in position to keep from falling, sinking or slipping.” This definition provides a nice visual when one thinks of the literal support

that is needed when an infant is brought home from the hospital and a family develops a new image.

Words were abstracted from the following questions that were posed to participants:

- a. Please tell me about the role social support has played for you in becoming a mom.
- b. How has social support helped you?
- c. What is your relationship like with your mother?
- d. Is there anything else I should know?

Variable name=support-mother.

1. KH5LN14-15 She will stay maybe next week and that has helped calm me down a lot.
2. KH5LN33 But we are definitely close and she is super supportive.
3. RR9LN 15 Very, very close, she is like my best friend. Ah yes, again, if I allowed her to she would have been more helpful.
4. RC10LN18 It's good. We have a very good relationship. We're close. I talk to her just about everything. She wants to help.
5. CK13LN19-21 My mom is typically a huge support in my life and I talk to her about whatever, but with her work schedule and everything lately she has not been able to provide me a lot of support.
6. CK13LN30-33 Um, for the most part really good. I can talk to her about whatever. She's not the most emotional or expressive person and, um, so she is really good to um go to with a problem to get advice or to, um, you know, have her help pick something out or whatever like even just to complain to or vent to for the most part she is pretty good but we joke around that she is 100% German and we're like you are so efficient because you are German. She never relaxes. If there is something task oriented, she is really good.

III. Words that reflect depression: Postpartum depression is not limited to the first six weeks postpartum, but can occur any time during the first year postpartum.

Postpartum depression is defined as any major depression within the first year postpartum in which patients have at least five of the following symptoms during the same two-week period:

1. Depressed mood most of the day.
2. Anhedonia most of the day.

3. Significant weight loss when not dieting, or weight gain, or change in appetite.
4. Insomnia or hypersomnia.
5. Psychomotor agitation or retardation.
6. Fatigue or loss of energy.
7. Feelings of worthlessness or excessive guilt.
8. Diminished ability to think or concentrate or make decisions.
9. Recurrent thoughts of death, or recurrent suicidal ideation, with or without a specific plan. (American Psychiatric Association, cited in Kendall-Tackett, 2005, p. 5. Reprinted with permission)

Words were abstracted from the following questions that were posed to participants:

- a. Have you felt or do you feel depressed now that you are postpartum?
- b. Please describe your experience now that you are postpartum.
- c. Is there anything else I should know?

Variable name=depression.

1. RC10LN 6 Yeah I think I felt depressed.
2. RC10LN6-11 I've been depressed before and, um, I kept thinking I'd be able to tell it was coming on—but like I kind of feel better, but it was actually my husband who said I seemed kind of depressed and I was like, yeah. I think I have been just—sorry what was the question? So yeah, I think I was depressed and I think he was right. He was correct. I think I have been depressed and I've had a lot of anxiety and I internalized a lot of anxiety. First it was my stomach, I was having really bad stomach aches—but that could be hormones, but also my back which is always an issue when I'm under stress. So you know I am definitely internalizing it. Um. I know change is always difficult for me.
3. CK13LN8 Um, I was surprised that I was more depressed during the first five weeks.
4. CK13LN9 I kept saying I wasn't happy.
5. CK13LN 11-14 Struggling with, you know, just you know. Not crying all the time but just different, um, catch me off guard. Like when I see someone on TV who might be pregnant it makes me really upset. Like I would say I eat a lot less and I don't know if it is because I'm doing things or holding him or whatever, you know I'm definitely eating a lot different than I had and, um, sleeping changes, um, you know it is all based on him so it's hard to say too.
6. JD12 LN 4-5 Occasional feeling sorry for yourself.

IV. Words that reflect incompetence: Incompetence is defined by the American Heritage Dictionary (2009) as “the lack of physical or intellectual ability or qualifications”.

Words were abstracted from the following questions that were posed to participants:

- a. Please describe your experience now that you are postpartum.
- b. Have you felt or do you feel depressed now that you are postpartum?
- c. What are some of the losses that you have experienced now that you are postpartum?
- d. What did you think mothering would be like?
- e. Is there anything else I should know?

Variable name=incompetence.

1. EC1LN12 I feel I should be able to do everything on my own.
2. EC1LN15 There are women that don't do it with that much help.
3. EC1LN25 In terms of loss—I think it is control.
4. RR9LN1-3 I wanted to say it was four weeks after having my daughter I started having extreme anxiety and it is hard for me to explain it. It was almost like paranoia. Fear of turning into one of those people that hurt their children—thinking that's what someone would do—but not acting on thoughts—extreme anxiety.
5. RR9LN11-12 I am so independent and I never want to burden anyone so that's the big problem.
6. RC10LN16-17 I have taken care of a lot of kids, my sister's kids. Like you know I've seen it, you know, but, it's so different when you're going through it. I guess I thought it was what I saw with my sister and her kids, babysitting, you know, no idea.
7. CK13LN2 Well I didn't exactly feel like a mother.
8. CK13LN 24-26 I wouldn't say I thought it would be easier. You know you always see the cartoons with the frazzled mom and whatever. But, I did think I would be able to handle it better because of all of my experiences with babysitting and, um, just how much I love kids and how good I am with them
9. JD12LN8-10 You think it's going to be rewarding right off the bat and you're just going to be happy all the time. For the most part it is true, but you don't realize how tired you are and how demanding it is—especially if you're breastfeeding—how on you have to be. You don't get any time to yourself. You don't realize how much you don't have for yourself.

10. LB3LN16-17 Am I supposed to be perfect? So that I think I am fine. Like when I go to that group, I see that I am not that bad. But, um, I don't feel as good as I would want to feel.

V. Words that reflect anxiety: Anxiety is defined as uneasiness and a state of apprehension.

According to DSM IV, Generalized Anxiety Disorder is defined as:

- A. At least 6 months of “excessive anxiety and worry” about a variety of events and situations. Generally, “excessive” can be interpreted as more than would be expected for a particular situation or event. Most people become anxious over certain things, but the intensity of the anxiety typically corresponds to the situation.
- B. There is significant difficulty in controlling the anxiety and worry. If someone has a very difficult struggle to regain control, relax, or cope with the anxiety and worry, then this requirement is met.
- C. The presence for most days over the previous six months of three or more (only one for children) of the following symptoms:
 1. Feeling wound-up, tense, or restless.
 2. Easily becoming fatigued or worn-out.
 3. Concentration problems.
 4. Irritability.
 5. Significant tension in muscles.
 6. Difficulty with sleep.
- D. The symptoms are not part of another disorder.
- E. The symptoms cause “clinically significant distress” or problems functioning in daily life. “Clinically significant” is the part that relies on the perspective of the treatment provider. Some people can have many of the aforementioned symptoms and come with them well enough to maintain a high level of functioning.
- F. The condition is not due to a substance or medical issue.

Source: American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th Ed., Text Revision). Washington, DC: American Psychiatric Association.

Words were abstracted from the following questions that were posed by participants:

- a. Please describe your experience now that you are postpartum.
- b. Have you felt or do you feel depressed now that you are postpartum?

- c. What did you think mothering would be like?
- d. Is there anything else I should know?

Variable name=anxiety.

1. RC10LN9 I've had like a lot of anxiety and I internalized a lot of anxiety.
2. RR9LN4 Anxiety and somewhat depressed appetite.
3. KH5LN6-7 I feel now it is a lot of anxiousness and anxiety—knots in my stomach. Every night at dinner it sets in.
4. SA4LN 3-4 I am not necessarily feeling sad but I am, um, kind of panicked sometimes. I feel freaked out—frustrated, not confident, um, nervous. Tears.

VI. Words that reflect loss: Loss can be defined as the condition of being deprived or bereaved of something or someone. Loss can also be best understood in relationship to Judith Viorst's book *Necessary Losses* (1986). She proposes that we grow and change through the losses that are an inevitable and necessary part of life. She argues that through the loss of our mother's protection, the loss of the impossible expectations we bring to relationships, the loss of our younger selves, and the loss of our loved ones through separation and death, we gain deeper perspective, true maturity, and fuller wisdom about life (Viorst, 1986).

Words were abstracted from the following questions that were posed by participants:

- a. Please describe your experience now that you are postpartum.
- b. What are some of the losses that you have experienced now that you are postpartum?
- c. Is there anything else I should know?

Variable name=losses.

1. JD12LN17-19 Loss of sleep and time by yourself and the relationship with my husband before he came. Um, but we get glimpses of what life used to be like when we go out for a whole two hours. Maybe loss of time. You definitely don't have time or maybe being able to go out by myself. Feeling like my own person.
2. JD12LN10 You don't realize how much you don't have for yourself.
3. RR9LN16-18 Yeah I guess the thing for me is already lost—my independence, when I had my first. Um I still lost sleep when I have toddlers—one is up and one is throwing up. I don't think it is really anything different with the first vs. the second.

4. HHLN15-17 Um. My independence. Like getting up and going. Um, like traveling, like we can't travel every week. Like putting on makeup or showering. Now I shower like every 2 or 3 days. Like you have to plan ahead more than I did in the past. I can't just get up and go. Loss of self.
5. KH5LN40 Probably the one thing I feel like I am kind of losing out on—progressing with my career.
6. RC10 LN22 I was sort of mourning the loss of an old chapter in my life.
7. LB2LN9 so just maybe the independence, just being in charge of just me.
8. CK13LN38 Loss, I definitely lost my independence and free time.
9. LB3LN 13 Structure in my life.
10. SA4LN13-18 I haven't really looked at these things as a loss until we talked. Um, I guess what I have lost is my, um, right now it feels like I have lost my old professional self, my professional confidence, and my own ability to speak and think clearly. I have managed to speak pretty clearly with you, but I promise, um, I lost practical things like a social life. I have certainly lost my sex drive. It is gone and I can't wait to have it back. I don't know when that is going to happen or what I can do to get it back. It sucks, but I have friends who nursed for a year and get their sex drive back. I guess it is a biological thing—but I really miss it. I have no desire and I am further away from George.

VII. Words that reflect pleasure in parenting: Pleasure in parenting can be observed when:

- a. Joy in child's development (baby smiling, rolling over, sitting up) is acknowledged.
- b. Joy in other intimacy with baby (holding or talking to baby) is expressed.
- c. Pride is present when others respond and acknowledge the baby.
- d. Pleasure is present in taking care of the baby.

Words were abstracted from the following questions that were posed by participants:

- a. Please describe your experience now that you are postpartum.
 - b. Is there anything else I should know?
1. RC10LN21 I just think the baby is just the biggest gain, you know, and I'm learning like.

VIII. Words that reflect sources of support:

Variable name=source of support.

1. SA4LN5 George my husband is my main support.
2. RC10LN12 I think my family is my best support.

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VITA

Carrie Feig was born and raised in Larchmont, New York. Before attending Loyola University Chicago, she attended Lafayette College, in Easton, Pennsylvania, where she earned a Bachelor of Arts in Psychology in 1996. From 1996-1999, she also attended New York University, where she received a Masters of Social Work.

While at Loyola, Carrie worked at Northwestern University as a clinical research coordinator. She was involved in the STAR*D treatment study for unipolar depression. Also, she worked as a therapist specializing in the treatment of mood disorders and other women's health issues, including relational issues, incorporating interpersonal, supportive, and cognitive behavioral methods.

Currently, Carrie continues to work as a therapist. Her focus is now working with women who are experiencing postpartum mood disorders. Additionally, she facilitates a New Moms Support Group at Northwestern University, Prentice Women's Hospital and lectures at the Transitions to Motherhood Class at Northwestern University, Prentice Women's Hospital.