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Women's Perspectives on Adequacy of Screening and Treatment for Postpartum Depression

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Abstract

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by

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MSN/MPH, Hunter College, 2003

BSN, Graceland University, 1999

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Postpartum depression affects some 10% to 20% of mothers. Its impact on the health and well-being of mothers and their infants is well documented. If not identified and addressed early, it can result in emotional burden, costly hospitalization and treatment, and, at worst, suicide and or infanticide. Empowerment theory was the conceptual framework for this hermeneutic phenomenological study. The purpose was to understand the lived experiences of the screening and treatment processes of 10 women from New York City experiencing postpartum depression and their perceived adequacy of the treatment received. In-depth interviews were used to investigate participants' lived experiences of the screening and treatment processes for their postpartum depression and to explore the extent to which they percieved that their emotional needs were met. From the responses to the interview questions, 6 themes emerged: crying and stress during and after pregnancy, inadequate assessment, feeling bad or unlike oneself, lack of understanding, needing to cope, and prayer was essential for recovery. Participants had tearfulness that began during pregnancy and intensified during the postpartum period, were ineffectively assessed, exhibited bizarre behaviors that could not be explained, had little understanding of what they were experiencing, and were sometimes misunderstood by others. Further, participants at times sought treatment on their own in order to cope. Some reported that prayer was central to the restoration of their mental health. Insights gained through this study can be utilized to foster positive social change by heightening awareness and assisting health care providers in planning appropriate screening and treatment to meet the individual needs of women with postpartum depression.

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Chapter 1: Introduction to the Study

Introduction

The birth of a child is often associated with much excitement and joy and the new mother is expected to gladly welcome her new role. For many mothers, however, this new role is far from an enjoyable experience because of postpartum depression. There are three conditions that are generally termed postpartum depression: postpartum or "baby" blues, postpartum depression or postpartum nonpsychotic depression, and postpartum psychosis (Seyfried & Marcus, 2003). These three conditions are generally differentiated by their duration and level of severity (Seyfried & Marcus, 2003).

The first condition, postpartum blues, occurs in as many as 50% of mothers, and researchers have described it as a transient mood disturbance (Miller, 2002). The symptoms of postpartum blues generally resolve within a few hours to a few days (Advance in Neonatal Care, 2003) and no treatment is required (Seyfried & Marcus, 2003). Emotional lability and happiness are the predominant symptoms (Miller, 2002; Seyfried & Marcus, 2003). Postpartum depression, the second condition, affects some 10% to 20% of mothers (Miller, 2002). Symptoms include insomnia, loss of appetite, inability to concentrate, feelings of ineffectiveness as a mother, and thoughts of harming the self or the infant (Miller, 2002). Symptoms generally persist for several weeks to several months and treatment is necessary (Seyfried & Marcus, 2003). Left untreated, postpartum depression can have long-term and devastating consequences (Dietz et al., 2007; Miller, 2002). The third condition, postpartum psychosis, is a psychiatric emergency. Symptoms include delusions, hallucinations, and suicidal and homicidal

thoughts (Miller, 2002). As Miller (2002) noted, women experiencing postpartum psychosis are more likely to act on suicidal or homicidal thoughts than women experiencing postpartum nonpsychotic depression. A more in-depth discussion of these three conditions and their effects or consequences appears in Chapter 2.

Background

Mood disturbance during the postpartum period has been documented since the days of Hippocrates (Miller, 2002). However, postpartum depression often goes unrecognized or underrecognized and untreated or ineffectively treated. The *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; American Psychological Association, 2000) defined postpartum depression as a major depressive illness with onset within the first 4 weeks after childbirth. Miller (2002) observed that scholars have proposed hormonal changes occurring within the first few weeks following delivery as a predisposing factor for postpartum depression. Miller noted that tragic familial events related to postpartum depression have resulted in increased public awareness of the problem and possibly to misconceptions about the prevalence of the disorder.

Dietz et al. (2007) evaluated the prevalence of maternal depression before, during, and after pregnancy among 4,398 women, using data from the Kaiser Permanente Northwest (KPNW) group practice health maintenance organization in Oregon and the state of Washington. The researchers chose women enrolled in KPNW continuously 39 weeks before and 39 weeks after pregnancy. Among the women, 678 were depressed at some point before, during, or after pregnancy. Mental health disorders specific to

pregnancy were identified in 11.8 % of the women. Of those who were identified as depressed before pregnancy, 54.2 % also experienced depression during or after pregnancy. The researchers found the prevalence of depression to be slightly higher during the postpartum period than before or during pregnancy and concluded that this was possibly due to the added burden of meeting the needs of the infant (Dietz et al., 2007).

Buist (2006), however, argued against "placing the infant as the cause of the problem" (p. 671) and admonished providers to be mindful that the onset of depression and anxiety often occurs during pregnancy. Further, women may not admit to being depressed due to fear of stigmatization or fear of being viewed as an incompetent mother (Buist, 2006). The mother may present with complaints of infant problems such as sleeping difficulties rather than with their own symptoms of postpartum mood disorders (Buist, 2006). Buist highlighted the need to provide supportive care or intervention that is caring and nonjudgmental and that is targeted to address the needs of both the mother and infant.

Effective pharmacological as well as nonpharmacological treatments are available for managing postpartum depression. However, postpartum depression must be identified and addressed early to prevent or minimize its harmful consequences. The consequences can be emotional, social, or economic and can be devastating for the mother, the infant, the family, and society (Paulden, Palmer, Hewitt, & Gilbody, 2008). Many mothers who suffer postpartum depression or psychosis have thoughts of harming themselves or their infant and, as Beck (2006) pointed out, the risk of suicide and or

infanticide is his high among these women. Therefore, early screening, identification, and intervention are essential to the well-being of the mother, infant, and family. Recognizing the threat of postpartum depression to the health and well-being of the mother and infant, the U.S. Department of Health and Human Services (2000) set a developmental goal in Healthy People 2010 objectives. The Healthy People 2010 document highlighted the need to recognize the medical as well as the mental health complications that may impact labor, delivery, and the postpartum (U.S. Department of Health and Human Services, 2000). Postpartum depression has continued to have an impact on the health and well-being of mothers and their families (Beck, 2006). However, while there was a Healthy People 2020 goal to increase the proportion of women who have a postpartum visit with a health care worker after giving birth, there were no goals that specifically addressed the issue of postpartum depression (U.S. Department of Health and Human Services, 2010).

The review of current literature revealed no study that explored women's view of the screening and treatment processes for postpartum depression. In this study, the aim was to address this gap. Health care providers can use the findings of this study to inform their practice in the screening and treatment of women experiencing postpartum depression.

Problem Statement

Despite evidence pointing to the value of early detection and treatment for postpartum depression, identification is often delayed and treatment often inadequate or not initiated (Ueda, Yamashita, & Yoshida, 2006). Left untreated, severe consequences can occur (Beck, 2006). The most severe of these consequences are maternal suicide and

infanticide. Early identification and treatment can prevent these adverse outcomes, but screening for postpartum depression is often inadequate, leading to missed opportunities to initiate early and appropriate management (Beck, 2006). The scientific literature was deficient in documenting women's experience of the screening and treatment process for postpartum depression. The purpose of this research was to provide an in-depth understanding of women's screening and treatment experiences for postpartum depression. Such understanding may help health care providers in partnering with postpartum depressed women to ensure timely assessment and management of their postpartum depression; thereby averting or minimizing adverse outcomes.

Purpose of the Study

The purpose of this qualitative study was to determine the extent to which postpartum women perceive that their emotional needs have been met during their initial postnatal visit and beyond and to describe their experiences of the screening process and clinical management of their postpartum depression. Today health care has moved from a paternalistic model of care to one of shared decisions in which the health care provider and client set mutually determined goals (Deegan & Drake, 2006). My hope was that findings from this study would address the question of whether or not postpartum depressed women feel that they are adequately screened and treated for postpartum depression. Determinations of how women perceive the screening and care they receive for their postpartum depression will help providers plan appropriate screening and care for women with postpartum depression.

Research Questions

In this study, two primary research questions were addressed. First, what is the lived experience of the screening and treatment process for women with postpartum depression? Second, to what extent do these women perceive that their emotional needs have been met during their initial postnatal visit and beyond?

Conceptual Framework

Empowerment theory (Hur, 2006; Perkins & Zimmerman, 1995; Peterson, et al., 2005) was used in this study to help in understanding the experience of postpartum depression for the study participants. Specifically, I used empowerment theory in the design of the interview questions. Hur (2006) noted that empowerment as a theory has its origin in the in the work of Paulo Freire, the Brazilian educator and humanitarian. Women experiencing postpartum depression have identified feelings of hopelessness (Advances in Neonatal Care, 2003; Seyfried & Marcus, 2003), powerlessness (Edhborg, Friberg, Lundh, & Widström, 2005; Ugarriza, 2002), and lack of control (Ugarriza, 2002) as issues that are significant features of their disorder. Empowerment may be viewed as a process, the goal of which is to allow individuals to attain the autonomy and self-esteem that will help them identify and meet their own health needs (Chambers & Thompson, 2008). Empowerment theory focuses on returning power and control to those experiencing powerlessness.

Additionally, Peterson, Lowe, Aquilino, and Schneider (2005) described empowerment as multidimensional or multilevel. Levels of empowerment include individual or personal, community, and organizational (Hur, 2006; Peterson, et al., 2005).

At the personal level, constructs of empowerment theory include meaning, competence, self-determination, and impact (Hur, 2006). Constructs of empowerment theory at the community or collective level, as Hur (2006) called it, include collective belonging, involvement in the community, control over organization in the community, and community building. A more detailed description of these constructs is presented in Chapter 2.

Nature of the Study

To answer the research questions, a hermeneutic phenomenological study was conducted. The data collection methodology that was used to investigate the research questions was individual, face-to-face interviews. A more detailed discussion of the research methodology and specific interview questions is presented in Chapter 3.

Definitions

Competence: Another construct of personal empowerment, competency involves one's belief that one has the skills and abilities necessary to capably fulfill one's responsibilities (Hur, 2006).

Empowerment: Empowerment is a process aimed at allowing individuals to identify and meet their own health needs through the attainment of autonomy and self-esteem (Chambers & Thompson, 2008).

Impact: Impact is a construct of personal empowerment in which one feels a sense of command over "organizational outcome" (Hur, 2006, p. 532).

Meaning: Meaning is conceptualized as a construct of personal empowerment that involves a balance between one's values, belief, behaviors, and role (Hur, 2006).

Postpartum depression: Postpartum depression is conceptualized as a depressive disorder characterized by two or more depressive symptoms lasting more than 14 days postdelivery (Seyfried & Marcus, 2003). There are three well-known postpartum psychiatric mood disorders generally termed postpartum depression: postpartum or "baby" blues, postpartum depression or postpartum nonpsychotic depression, and postpartum psychosis. The "baby blues" typically begin 3 days postdelivery and usually resolve within a few hours to as many as 14 days and do not require treatment (Seyfried & Marcus, 2003). Women experiencing the "baby blues" were excluded from the study. Postpartum depression or postpartum nonpsychotic depression and postpartum psychosis typically continue for more than 14 days postdelivery and resolution typically require some intervention (Seyfried & Marcus, 2003).

Screening: Screening is an assessment aimed at identifying cases of postpartum depression. Such assessment may or may not involve the use of a screening tool (Gjerdingen & Yawn, 2007).

Self-determination: Self-determination is conceptualized as a construct of personal empowerment in which one experiences a sense of personal control over one's responsibilities (Hur, 2006).

Treatment: Treatment is defined as pharmacological and or nonpharmacological interventions employed in the management of postpartum depression (Suri & Altshuler, 2004).

Assumptions

It was assumed that participants would be willing to share their experiences and provide open, honest answers to questions. Further, it was assumed that the study participants would have opinions on the screening and management of their postpartum depression that they would disclose. However, I anticipated that it was possible that the study participants may perceive the questions and recording of answers as intrusive and be reluctant to fully disclose their true feelings and views about their experiences. The usefulness of the information provided would be limited if participants had not answered questions honestly.

Scope and Delimitations

This study focused on lived experiences of the screening and treatment process for women with postpartum depression. Ten women from New York City were recruited and interviewed. The women were recruited through distribution of a flyer at the Postpartum Resource Center based on Long Island, Caribbean Women's Health Association (CWHA) in Brooklyn, the East Side Women's OB/GYN Associates in Manhattan, Downtown Women OB/GYN Associates, and SoHo Obstetrics and Gynecology Practice in Manhattan. The Postpartum Resource Center also posted the flyer to their Facebook page.

This study was limited to women 18 years or older who experienced the second most serious of the three postpartum conditions, postpartum depression. Those experiencing postpartum blues or postpartum psychosis were not included. Further, participation was limited to women who were able to read and speak English, were

mothers of one or more children, were 8 or more months postpartum, received treatment for postpartum depression, and who may or may not have had an ongoing relationship with their partners. While the study findings may add to the body of knowledge on postpartum depression, findings were limited to the study participants and cannot be generalized to all women who experience postpartum depression.

Limitations

There were several limitations to this study. First, there was the difficulty of recruiting participants who were trusting and willing to share their experiences of postpartum depression. It is likely that this difficulty in recruiting participants stemmed from concerns by individuals experiencing mental disorders about being stigmatized or labeled as "crazy". Horowitz and Cousins (2006) noted the impact that fear of stigmatization can have in reducing treatment rates; some women may fail to discuss their feelings or fail to seek treatment. Of 21 women who expressed an interest in participating in the study, 11 were excluded; five because they reported experienced "the blues" rather than postpartum depression, five who withdrew after hearing the description of the study, and one who failed to follow-up after the initial contact to inquire about the study. The five who withdrew did not want their interviews recorded despite my assurances of privacy and confidentiality. It is possible these five women also had concerns about being labeled as crazy.

A second limitation to this study was that findings could not be generalized to all sufferers of postpartum depression. This study provided some understanding into some women's experience of postpartum depression. It is still necessary for providers to

evaluate each woman and provide individualized care based on each woman's individual needs and desires. Also, this study was a phenomenological inquiry and therefore did not provide quantitative descriptions of postpartum depression. The study findings were limited to interpretation of identified themes.

The possibility of introducing response and interviewer bias into the study was also considered as a possible limitation. Response bias occurs when questions are constructed in such a way that respondents choose a particular answer or answer in a particular way based on the researcher's desires. Response bias also occurs if the presence of the interviewer influences the respondents' answers (Babbie, 2004). The interviewer, also, can cause bias in a number of ways that include the tone of the interviewer's questioning and body language. Consideration was given to the way in which questions were constructed so as to minimize these biases. Further, questions were presented in a similar manner for each interview to minimize interviewer bias. In the analysis of qualitative data, it may be difficult to determine whether or not these biases exist. However, one can examine the questions to see if there is any likelihood of bias in the way the questions are phrased (Babbie, 2004). The interview questions were constructed based on empowerment theory, thereby giving the questions a narrower focus and further minimizing the risk of introducing bias into the study.

Significance

Paulden, Palmer, Hewitt, and Gilbody (2008) viewed depression as the most burdensome of all mental health illnesses. They argued that postpartum depression affects at least 11% of women and is therefore a significant category of depression. For many

mothers experiencing postpartum depression, the disorder is prolonged and very debilitating. Sword, Busser, Ganann, McMillan, and Swinton (2008) pointed out that postpartum depression is the most common mental disorder experienced by women postpartum and is a negative outcome for women across diverse cultures. There are, however, certain factors linked to the development of postpartum depression and predispose certain groups to its development.

The Centers for Disease Control and Prevention (CDC) conduct ongoing surveillance of maternal attitudes and experiences before, during, and after delivery of a live infant through self-reporting to the Pregnancy Risk Assessment Monitoring System (PRAMS). Based on data received from 17 states, the CDC (2008) reported that, within 1 year after giving birth, some 10% to 15 % of women experienced postpartum depressive symptoms. The PRAMS data revealed that the prevalence of postpartum depression was higher in younger mothers and those who had experienced partner or marital discord or were involved in an abusive relationship. Significant associations were found between postpartum depression and tobacco use during the third trimester of pregnancy, physical abuse before or during pregnancy, trauma-related stress during pregnancy, economic hardship during pregnancy, emotional distress during pregnancy, and giving birth to a low birth weight infant (CDC, 2008).

Many mothers who suffer postpartum depression or postpartum psychosis have thoughts of harming themselves or their infant, and the rates of suicide and infanticide among these women are high (Beck, 2006). The infant is dependent on the mother for its health and well-being; postpartum depression therefore poses a potentially significant

threat to the health and well-being of the infant (Seyfried & Marcus, 2003). In cases of infanticide committed by mothers experiencing postpartum depression, Spinelli (2004) argued that there is a feeling of ambivalence in society. On one hand, there is an expression of sorrow, anger, and outrage at the killing of an innocent, defenseless infant at the hand of someone who is expected to be its protector. On the other hand, there is the imprisonment of the mother, whom Spinelli viewed as a victim because her mental illness caused her to kill her infant.

The societal consequences of postpartum depression are not limited to suicide and infanticide. Wisner, Chambers, and Sit (2006) described postpartum depression as a major public health problem and argued that it "affects crucial infant and adult developmental processes" (p. 2616). They observed that, in children, the negative impact on the mother-infant bond can "increase the risk of impaired mental and motor development, difficult temperament, poor self-regulation, low self-esteem, and behavior problems" (p. 2616). Thus, postpartum depression can negatively affect childhood development.

Despite evidence that early identification and management can positively alter the course and consequences of postpartum depression, many cases reportedly have gone underrecognized and inadequately managed (Beck, 2006). The social change implication of this study, I hope, is that this study will result in a greater understanding of women's perceptions of the screening and treatment processes for postpartum depression, which will enhance health care providers' knowledge. This knowledge acquisition will be the impetus that will spur these providers to seek to timely identify and partner with these

women to adequately meet their needs. Further, this study will help in heightening public awareness of postpartum depression as a public health problem for which prevention should be a major goal. By enhancing public understanding of the issue of postpartum depression, progress may be made toward the social change needed to make prevention a greater focus of public health. Societal change is also needed in the judicial system's handling of women whose postpartum psychosis causes them to kill their infants.

Summary

Postpartum depression is a complex mood disturbance that can severely impact the woman, her children, her family, and society. Traditionally, societal expectation is that the birth of a child is a joyous experience for a mother and that she will adapt readily to her new role. Postpartum depression deprives the mother of the joy of motherhood and leaves her functionally and emotionally impaired and doubting her ability to be a competent mother. Women experiencing postpartum depression have reported symptoms of insomnia, emotional lability, lack of appetite, and feelings of powerlessness and lack of control (Seyfried & Marcus, 2003; Ugarriza, 2002). Many had thoughts of harming themselves and or their infants. Research has shown that postpartum depression is often unrecognized and untreated (Gjerdingen & Yawn, 2009). Left untreated, the woman's emotional state and her symptoms of postpartum depression may worsen, the course of the disorder prolonged, and the potential for the most severe consequences of suicide and infanticide increased (Morris-Rush & Bernstein, 2002). Early recognition and adequate treatment are important in combating postpartum depression (Gjerdingen & Yawn, 2009).

The goal of this study was to understand women's experiences of the screening and treatment processes for their postpartum depression. Based on the study findings, the question of whether or not women perceived that they were adequately screened and treated for postpartum depression was addressed. My goal was for the study findings to help providers in planning appropriate screening and care for women with postpartum depression to ensure that their individual needs are met.

A review of the literature on postpartum depression is presented in Chapter 2. A detailed description of the research methodology is presented in Chapter 3. Chapter 4 describes the study findings. An interpretation of the study findings, implications for social change, recommendations, and the conclusion appear in Chapter 5.

Chapter 2: Literature Review

Introduction

"The joy of motherhood" is an expression often heard in discussions about pregnancy and childbirth because people generally believe that such events are filled with bliss for the expectant or new mother. However, the joy of motherhood is for many expectant and new mothers a myth (Advances in Neonatal Care, 2003; Beck, 2006). Even normal fear may cause pregnancy and childbirth to be far less than a joyous experience for some women (Beck, 2006). For many women, motherhood brings great distress and little or no joy because of their affliction with what is generally termed postpartum depression. Not only does postpartum depression take the joy out of being a mother, but, depending on the severity of the depression, it can also be life threatening for both the mother and infant, as those who are most severely depressed are most likely to act on suicidal and homicidal ideations (Miller, 2002).

In recent years, there has been an increase in the focus on postpartum depression. Many studies have been conducted to determine its causes, to determine the most effective screening approaches, to identify effective treatment modalities, and to understand its effect on the child and family (Beck, 2002; Beck, 2006; Condon, 2006; Gjerdingen & Yawn, 2009; Logsdon, Wisner, & Pinto-Foltz, 2006). Few studies have explored women's experience of postpartum depression. Specifically, there is a paucity of studies that have sought to understand the perspective of the screening and treatment processes from the viewpoint of those who experience postpartum depression. In this qualitative study, the perceived adequacy of the screening and treatment experiences of

women experiencing postpartum depression was assessed. The goal was that this assessment would add to the understanding of postpartum depression.

Before discussing the findings of this literature review, the search strategy for locating articles is described. Next, a detailed description of the problem of postpartum depression is presented. A review of empowerment theory is also presented, with the aim of adding to the understanding of how scholars have viewed postpartum depression. Additionally, a review of the related research including research on the effects of postpartum mood disorders, treatment modalities, and treatment decisions is presented.

Literature Search Strategy

Several sources of information were consulted in the collection of material for this literature review. Online databases such as PubMed, Medline, and Medscape were accessed using search terms such as *postpartum, postnatal, postpartum depression, postnatal depression, postpartum mood disorders*, and *postpartum psychosis*. Additional search terms included *treatment* and *screening*. PsychInfo and CINAHL were also accessed using Walden University's online library and inputting the above search terms. A review of the references used in the articles found through the previously described search strategies was also used to identify additional articles. Full-text articles were retrieved from EBSCO host, the Long Island College Hospital Library, the Metropolitan Hospital Center Library, and the Montefiore Medical Center Library. Some articles were also obtained from other online sources that offered free full-text articles. The full-text of some articles was not available for free online. For these articles, the abstracts were retrieved online and the full-text later obtained from a library.

Conceptual Framework

Women experiencing postpartum depression often express a feeling of hopelessness (Advances in Neonatal Care, 2003; Seyfried & Marcus, 2003), powerlessness (Edhborg et al., 2005; Ugarriza, 2002), and lack of control (Ugarriza, 2002). Empowerment theory, which is focused on returning power and control to those experiencing powerlessness, may help in addressing postpartum depression. Perkins and Zimmerman (1995) observed that there are numerous definitions of empowerment. Perhaps this abundance of definitions is the reason Chambers and Thompson (2008) argued that empowerment is a difficult concept to define. Chambers and Thompson viewed empowerment as a process aimed at affording individuals the autonomy and self-esteem to identify and address their own health needs. Another conceptualization of empowerment is that it is "a social-action process through which people gain greater control, efficacy, and social justice" (Peterson et al., 2005, p. 233). Further, Peterson et al. (2005) pointed out that researchers have "often conceptualized empowerment as a multilevel (multi-dimensional) construct that includes individual, organizational, and community level of analysis" (p. 234).

Perkins and Zimmerman (1995) further demonstrated the multidimensional nature of empowerment. They observed that "theoretically, the construct connects mental health to mutual help and the struggle to create a responsive community" (p. 569). Empowerment research, they observed, centers on determining capabilities and examining environmental determinants of social problems rather than classifying risk factors and assigning blame. "Empowerment-oriented interventions enhance wellness

while they also aim to ameliorate problems, provide opportunities for participants to develop knowledge and skills, and engage professionals as collaborators instead of authoritative experts" (Perkins & Zimmerman 1995, p. 570).

Chambers and Thompson (2008) acknowledged the difficulty professionals often have conceptualizing the term empowerment and pointed to the work of MacDonald (1998), who argued that empowerment resulted from an effort against authoritarianism. Chambers and Thompson investigated nurses' understanding of the term empowerment and their use of the concept when engaged in health promotion activities in the acute care environment. Participants were 20 registered nurses who worked in an acute care setting in the United Kingdom. Study data were collected using six vignettes. The nurses were asked to say how they would plan for the health promotion needs of the subjects in the vignettes. The study found that some nurses conceptualized empowerment as a process through which knowledge is used to change patients' behaviors while others viewed empowerment as a way to provide care to disempowered individuals who were incapable of making decisions for themselves (Chambers and Thompson, 2008).

While many researchers have focused on empowerment as an outcome, Hur (2006) examined empowerment as a process. Hur reviewed empowerment literature and described the process of empowerment in various fields. In the field of health studies, empowerment involves "discovering reality, developing the necessary knowledge, fostering competence, and employing confidence for making their voices heard" (Hur, 2006, p. 527). Further, Hur's analysis of the literature showed that alienation, awareness, participation, and a sense of community were interconnected steps leading to

empowerment. The reality of powerlessness and alienation is the first step in the empowerment process. The second step in the process is the realization or awareness that there is lack of power and the possibility to gain power and change one's situation. The third step involves taking the initiative to mobilize the disempowered and share power with them through collective action. Hur noted that empowerment continues beyond the third step because it grows and is maximized by involving the masses. Hur argued that "maximized human empowerment can be practiced at the final stage to overcome social oppression and achieve social justice" (p. 530).

The analysis also showed two interrelated categories of empowerment, personal or individual empowerment and collective empowerment. Personal empowerment develops when individuals seek to acquire "the capabilities to overcome their psychological and intellectual obstacles and attain self-determination, self-sufficiency, and decision making abilities" (Hur, 2006, p. 531). Collective empowerment occurs as a result of people joining forces to overcome barriers or obstacles to social change. Personal empowerment and collective empowerment each has its own set of four components. The components of personal empowerment include meaning, competence, self-determination, and impact (Hur, 2006). Meaning and competence are viewed as interconnected concepts of mastery, defined as having total control of someone or something. Meaning is said to "involve a fit between the needs of one's work role and one's values, belief, and behaviors" (Hur, 2006, p. 532). Competency is the belief that one has the skills and abilities required to ably perform one's responsibilities. Self-determination refers to one's sense of personal control over one's work. Impact, on the

other hand, refers to "the individual's sense of control over organizational outcome" (Hur, 2006, p. 532).

The components of collective empowerment include collective belonging, involvement in the community, control over organization in the community, and community building. Collective belonging refers to being part of a "social network of peers" (Hur, 2006, p. 533). Involvement in the community means active engagement in community affairs aimed at affecting change or redistributing power within the community (Hur, 2006). Control over organization in the community refers to the exertion of influence over community organizations through group support, advocacy, and political control. Community building relates to the development of a sense of social cohesion among the populace that will enhance "their ability to work together, problem solve, and make group decision for social change" (Hur, 2006, p. 534).

Hur (2006) declared that there is a strong interconnectedness between empowerment and power. Applying empowerment concepts to the issue of postpartum depression has the potential to help women experiencing postpartum depression gain mastery over their situations. Kabeer (2001) discussed three dimensions of empowerment. These are resources, agency, and achievements. Kabeer viewed resources as the conditions under which an individual makes choices; agency as the process by which choice is made; and achievements as the outcomes of choices. Through screening, women who are experiencing postpartum depression can be identified and directed toward the necessary resources that will help them make choices or decisions that will aid their recovery.

Researchers have recommended that assistance with childcare be included in the treatment process. Kauppi, Kumpulainen, Vanamo, Merikanto, and Karkola (2008) cautioned that, while treatment may result in empowerment, assistance should be provided in caring for the baby, as childcare activities can be overwhelming. If childcare leaves the mother feeling "helpless and tired, empowerment may activate her without changing the stress and may lead to suicidal and filicidal behavior" (Kauppi et al., 2008, p. 205). Empowerment may lead to awareness, but if the mother does not have the support needed to help in overcoming childcare-associated stress, she may not be able to achieve mastery and competence necessary for recovery.

As previously noted, the empowerment process fosters self-esteem and autonomy and enables individuals to identify and address their own health needs (Chambers & Thompson, 2008). Further, as Perkins and Zimmerman (1995) noted, empowerment-based interventions enhance wellness, ameliorate problems, and fosters collaboration between the professional and patient. In this study, I used empowerment theory to construct the interview questions. Questions were constructed to elicit information on elements of empowerment theory as well as the participants' perception of the screening and treatment processes for their postpartum depression.

Health Problem

Beck (2006) described postpartum depression as a "crippling mood disorder" (p. 40) that can severely impact the mother-infant dyad. Seyfried and Marcus (2003) observed that postpartum depression poses a potentially significant threat to the health

and well-being of the infant due to the infant's dependence on its mother for its health and well-being.

Generally, postpartum depression refers to three conditions; postpartum or "baby blues", postpartum depression, and postpartum psychosis (Advances in Neonatal Care, 2003; Kendall-Tackett, 1994). However, researchers, in current literature, placed postpartum depression on a continuum of postpartum mood disorders that ranges from the "baby blues" to postpartum psychosis (Beck, 2003; Buist, 2006). Where an individual falls on the continuum is dependent on the number and type of risk factors the individual possesses (Buist, 2006). Additional postpartum mood disorders that have been identified include postpartum panic disorder, postpartum obsessive-compulsive disorder, postpartum bipolar II disorder, and postpartum posttraumatic stress disorder (Advances in Neonatal Care, 2003; Beck, 2006; Ross & McLean, 2006). Beck (2003) pointed out that these postpartum mood disorders each has its own distinctive symptoms and that it is important to distinguish between postpartum depression and other postpartum mood disorders. A description of the three conditions that are generally referred to as postpartum depression follows.

Postpartum Blues

Postpartum blues is a common transient disturbance in mood occurring in some 30% to 75% of new mothers (Seyfried & Marcus, 2003; Suri & Altshuler, 2004). Symptoms generally resolve within a few hours to a few days (Advances in Neonatal Care, 2003). Most commonly, women who experience postpartum blues demonstrate emotional lability (Seyfried & Marcus, 2003). Other manifestations of postpartum blues

include sleep disturbance, irritability, anxiety, headache, fatigue, and subjective feelings of confusion, lack of concentration, and absent-mindedness (Advances in Neonatal Care, 2003; Seyfried & Marcus, 2003; Suri & Altshuler, 2004). Seyfried and Marcus (2003) observed that some researchers disagree as to whether a depressed mood is characteristic of the blues while others, however, found a depressed mood to be a feature of the blues. Some researchers, Seyfried and Marcus noted, found the tearfulness of the blues to be not related to sadness but rather to happiness.

The blues has no clear diagnostic criteria and no clearly identified etiology. According to Seyfried and Marcus (2003), circulating hormone levels and psychosocial factors have been the focus of much of the research into the cause of the blues but the cause remains elusive. Postpartum blues "is self-limiting and requires no specific treatment other than education and support" (Seyfried & Marcus, 2003, p. 231). Some 20% of women who experience the blues will progress to postpartum depression; therefore reassurance and support is needed (Suri & Altshuler, 2004).

Postpartum Depression

Seyfried and Marcus (2003) defined postpartum depression as "a non-psychotic depressive episode" (p. 233) that may begin or extend into the postnatal period. Postpartum depression is the most common psychiatric postpartum mood disorder (Suri & Altshuler, 2004). It reportedly occurs in 10% to 22% of new mothers and generally occurs within 4 weeks postdelivery (Seyfried & Marcus, 2003). Symptoms of postpartum depression may include a lack of interest or pleasure in usual activities, significant loss or gain in weight, loss of appetite, low self-esteem, insomnia or hypersomnia, significant

fatigue or energy loss, feelings of worthlessness or hopelessness, feelings of guilt, a decreased ability to think or concentrate, and recurrent thoughts of suicide or thoughts of harming the infant (Advances in Neonatal Care, 2003; Seyfried & Marcus, 2003). Having five or more of the previously identified symptoms, lasting 2 or more weeks, is diagnostic of postpartum depression.

Seyfried and Marcus (2003) pointed out that several of the symptoms of postpartum depression overlap with normal experiences of the postpartum period. Such normal experiences include fatigue, sleep disturbance, and changes in weight. Because of this overlap, Seyfried and Marcus observed, some depression scales may have a high rate of false positives. The Edinburgh Postnatal Depression Scale (EPDS) is one scale that is found to be fairly accurate, easy to administer, and has been validated in several studies (Seyfried & Marcus, 2003).

The etiology of postpartum depression, like that of the blues, is unclear. Biological and psychosocial factors have also been considered in an effort to understand the etiology of postpartum depression (Seyfried & Marcus, 2003). Seyfried and Marcus (2003) discussed evidence suggesting that there are some women with postpartum depression secondary to thyroid dysfunction; however a link to changes in the circulating levels of other hormones has not been found. There has also been no consensus among researchers on a link to psychosocial factors. “A woman’s personal psychiatric history, has been consistently found to be a risk factor” (Seyfried & Marcus, 2003, p. 234). Some evidence indicates that women with a prior history of psychiatric depressive disorders are at risk for postpartum depression. Seyfried and Marcus suggested that the association

between postpartum depression and obstetrical complications is more inconsistent than the association between postpartum depression and marital discord and lack of social support.

Women who experience postpartum depression are predisposed to later episodes of depression (Seyfried & Marcus, 2003). According to Seyfried and Marcus, treatment for postpartum depression is generally the same as for a major depressive episode not related to parturition. Treatment is primarily pharmacological but some nonpharmacologic treatment is available to women who may prefer to have no medication (Seyfried & Marcus, 2003).

Postpartum Psychosis

Seyfried and Marcus (2003) also discussed postpartum psychosis and stated that it occurs in one to two new mothers per 1,000. They noted that the onset typically occurs within the first 2 weeks postdelivery and that symptoms include elation, mood lability, distractibility, increased activity, delusions, hallucinations, and an inability to function. Other symptoms of depression including feelings of guilt and worthlessness, cognitive disorganization, bizarre behavior, and suicidal and homicidal ideations may also be present.

Some evidence indicates that there is a relationship between postpartum psychosis and bipolar disorder (Seyfried & Marcus, 2003). As Seyfried and Marcus pointed out, women with bipolar disorder and a family history of postpartum psychosis appear to be at greater risk for postpartum psychosis. Further, they point to a relationship between postpartum psychosis and biological factors. In their discussion, they noted that

generally there seem to be no significant association between biological factors and postpartum psychosis. However, there is evidence that suggests an association between postpartum thyroiditis and postpartum psychosis (Seyfried & Marcus, 2003). Additionally, primiparous women have been found to be more at risk for postpartum depression (Seyfried & Marcus, 2003).

The impact of postpartum psychosis can be very severe for both the mother and infant and suicide and infanticide, although rare, can result (Spinelli, 2004). Mood stabilizer and antipsychotic medications are often required to treat postpartum psychosis (Seyfried & Marcus 2003).

Effects of Postpartum Mood Disorder

The burden of postpartum depression has significant implications for the mother and also her partner and infant. Researchers have found deleterious effects in both fathers and infants of women experiencing postpartum depression. The negative impact on fathers and infants often further compromises the mothers' mothering abilities (Condon, 2006; Logsdon, Wisner, & Pinto-Foltz, 2006).

Mothers and Postpartum Depression

Adjustment after parturition. For postpartum women, the expected transition during the postpartum period involves a physical recovery from parturition, attention to the care needs of the infant, assistance with sibling adjustment, adaptation to new roles, and fulfillment of social expectations (Landy, Sword, & Valaitis, 2009). For those who are socioeconomically disadvantaged, Landy et al. pointed out, the transition can be especially challenging. These women are more likely to experience postpartum

depression, nutritional deficiencies, and other adverse health outcomes (Landy et al., 2009). Further, they are more likely to lack social support and to experience violence at the hands of intimate partners (Landy et al., 2009).

Experiences of the socioeconomically disadvantaged. Landy et al. (2009) used a qualitative descriptive approach to examine and describe the experiences of socioeconomically disadvantaged postpartum women. The study participants were 24 postpartum women recruited from four southern Ontario hospitals. The researchers found two broad themes. The first was "ongoing burden of their day-to-day lives" with subthemes of "poverty and material deprivation, stigmatization through living publicly examined lives, and precarious social support" (Landy et al., p. 196). The second was an "ongoing struggles to adjust to changes" resulting from their infants' births (Landy et al., p. 196). Subthemes linked to this second theme included "the first weeks were hard, feeling out of control, absence of help at home, complex relationship with baby's father, and health and wellbeing" (Landy et al., p. 196).

Expectations versus reality of motherhood. According to Edhborg et al. (2005), in a meta-synthesis of qualitative studies, there were indications that women experiencing postpartum depression perceived a significant difference between the expectation and reality of motherhood. They observed that mothers described having a sense of downward spiraling and a feeling of overwhelming loss. This, they observed, has led some researchers to conceptualize motherhood as being characterized by a sense of loss with the most important loss being the loss of identity.

In their study, Edhborg et al. (2005) used grounded theory to explore and describe the experiences of postpartum depressive symptoms in a group of Swedish women. Mothers in this study reported feelings of separation from their work and their identity as competent professionals. Many of the mothers felt a loss of their physical and emotional selves. The researchers found that the central theme among the study participants was a sense of "struggling with life" (Edhborg et al., p. 263). The mothers reported experiencing overwhelming feelings of "failure, guilt, disappointment, worries, loneliness, uncertainty, bereavement, and unfulfilled expectations" (Edhborg et al., p. 263). The mothers also reported having difficulty relating to the self, their infants, and their partners.

The mothers had definite moral views and expectations of the conduct of a good mother and experienced feelings of guilt for failure to meet these expectations (Edhborg et al., 2005). The mothers, the researchers noted, also struggled with the issue of childcare. They felt unprepared and uncertain to fulfill their role as parents. Mothers who felt no initial emotional attachment to their infants experienced feelings of guilt and regret. Several mothers dreaded being alone with their infants. They expressed feelings of being tethered to the infant and yearned for the support of and interaction with other adults.

The mothers also had difficulty expressing their feelings to relatives and friends for fear of having their belief of being bad mothers validated or of being seen as dissatisfied without having a valid reason for such dissatisfaction (Edhborg et al., 2005). The authors noted that "the mothers felt unnatural as mothers and assigned their

depressed feelings to personal weakness rather than to illness and they felt guilt and failure, which made them reluctant to talk about their feelings" (Edhborg et al., p. 265).

Interaction with the infant and partner. The new role caused fatigue in some mothers and left them feeling guilty for not having enough energy to care for and interact with the infant for longer periods of time (Edhborg et al., 2005). Edhborg et al. (2005) noted that motherhood also resulted in marital discord as partners had less time for each other and communicated with each other less often. Some mothers reported increased misunderstanding with their partners and felt that the fathers were not helpful or supportive (Edhborg et al., 2005). Others reportedly encouraged the fathers' involvement in the care of their infants and felt that the fathers were supportive (Edhborg et al., 2005). Despite this however, they felt that there were negative changes in their relationships with the fathers (Edhborg et al., 2005).

Women's perspective versus biomedical perspectives. Ugarriza (2002) observed that, in the United States, postpartum depression is a phenomenon that is not well understood. The biomedical perspective may differ from the perspective of those experiencing postpartum depression (Ugarriza, 2002). To better understand women's perspectives of postpartum depression and to help in reconciling the difference in the women's and the biomedical perspectives, Ugarriza interviewed 28 women self-identified as experiencing postpartum depression. Generally, the women believed several factors contributed to their depression. Some mothers, influenced by their physicians' explanations of the cause of their depression, believed that their depression resulted from biochemical or hormonal changes. Others believed that their role change was the most

important factor in the development of their depressive symptoms. For others, their unsuccessful attempts at breastfeeding or a difficult birthing experience were viewed as the major cause of their depression. Postpartum depression caused overwhelming sadness, sleep deprivation, lack of confidence in fulfilling their roles as mothers, powerlessness, and loss of control. Mothers also expressed feelings of anger, fear, guilt, and shame because they had thoughts of harming their infants.

Potential for suicide or infanticide. Perhaps the most troubling and burdensome feature of postpartum depression is the potential for suicide or infanticide. Lindahl, Pearson, and Colpe (2005) noted that, in the United States, recent incidents have heightened public awareness of the issue of postpartum depression and its potential devastating outcomes. Lindahl et al. pointed out that it is not uncommon for women experiencing postpartum psychosis to attempt suicide or self-harm. Citing a dearth of information on suicidality during pregnancy and the postpartum, Lindahl et al. conducted a literature review to determine suicide prevalence rates during pregnancy and the postpartum. The review included both published and unpublished work. The authors conceptualized suicidality "to include suicide deaths, intentional self-harm (with or without intent to die), and thoughts of death and self-harm" (Lindahl et al. p. 77). The authors noted that a previous suicide attempt can result in a significantly increased risk of suicide death. The review indicated a lower suicide rate and suicide attempts among pregnant and postpartum women than women in the general population. However, pregnant and postpartum women were found to use more deadly suicide methods. The

authors concluded that pregnant and postpartum women selection of more violent suicide methods is indicative of a greater level of intent.

Fathers and Postpartum Depression

Adjustment to fatherhood. Pregnancy and childbirth requires some adjustment on the part of the mother. Condon (2006) observed that fathers are required to make similar adjustments. Condon further observed that healthy adjustment to fatherhood is dependent on the successful accomplishment of four psychological tasks. The first task is the development of an attachment to the fetus. A dramatic increase in fetal attachment is believed to occur at 16 to 20 weeks gestation and is related to the ability to feel or palpate fetal movements (Condon, 2006). "Depression or a dysfunctional partner relationship" (Condon, p. 690) may hamper or inhibit paternal fetal attachment while "encouraging the father's involvement in the pregnancy" (Condon, p. 690) may promote paternal fetal attachment. The second task involves making the adjustment from a dyad to a triad. The accomplishment of this task may be hindered if the father has difficulty sharing the mother with the fetus. If there is a decline in sexual activity during the pregnancy, the father may find sharing even more difficult. The third task involves "conceptualizing the self as father" (Condon, p. 691). Condon (2006) observed that if the man is still "emotionally a needy child" (p.691) he will have difficulty accomplishing this task as he will look to the child to help in meeting his needs. The final task involves the determination of one's own parenting style. Condon (2006) argued that men often do not want to emulate their own fathers in their relationship with their own children.

Response to the mother's depression. The father's response to his partner's depression can significantly influence the outcome of such depression (Condon, 2006). An initial supportive attitude may be replaced by a "more critical or even punitive" (Condon, 2006, p. 691) attitude. Symptoms of postnatal depression such as irritability and withdrawal from physical affection may be perceived by the male partner as rejection and lead to anger, resentment, and maladaptive behaviors on the part of the male partner (Condon, 2006). This is likely to increase the woman's distress (Condon, 2006). If it becomes necessary for the father and others to assume greater responsibility for the care of the infant, Condon (2006) pointed out, the mother may see this as proof of her incompetence as a mother.

Paternal postpartum depression. Some men are believed to experience postpartum depression (Paulson & Bazemore, 2011). Although Condon (2006) argued that the phenomenon of paternal postpartum depression is questionable, there is evidence (Goodman, 2004) indicating that paternal postpartum depression does exist. To further elucidate the issue of paternal postpartum depression, Goodman (2004) conducted a study aimed at examining the incidence, characteristics, and predictors of paternal postpartum depression. Additionally, Goodman sought to examine the relationship between paternal and maternal postpartum depression and the impact of parental depression on the family and infant. Goodman reviewed articles from 1980 to 2002 and found that paternal depression is not commonly discussed or recognized in the literature. Points at which data on paternal postpartum depression were collected ranged from 3 days to 12 months postpartum. Measurement for paternal postpartum depression was the same as for

maternal postpartum depression. Generally the incidence of paternal postpartum depression ranged from 1.2% to 25.5%. However, 24% to 50 % of fathers experienced postpartum depression when the mothers were suffering from postpartum depression. The evidence suggested that the onset of maternal postpartum depression often preceded the onset of paternal postpartum depression. The incidence increased over time with few fathers reporting postpartum depression in the earlier months than in the later months of the first year. Fathers who experienced postpartum depression had mild (69%) to moderate (30.8%) depression. Approximately 50% of those with self-reported depressive symptoms at 6 weeks postpartum were still depressed at 6 months postpartum. Several risk factors for paternal postpartum depression were identified; these included personal history of depression, antenatal or postnatal history of depression in the partner, and a dysfunctional relationship with the partner. However, the major predictor of paternal postpartum depression was maternal depression. The risk to the child is great when one parent is depressed. When both parents are experiencing depression the risk is even greater. Goodman concluded that, given the risk to the child and other members of the families, the standard of care for postpartum depression should include the screening of men for depression.

Postpartum Depression and Infant Care

Infants are not immune to the impact of their mother's depressive symptoms. For the infant, the impact of postpartum depression can be especially severe. Studies have demonstrated adverse effects for the infant in several areas in the presence of postpartum depression (Logsdon et al., 2006; Paulson, Dauber, & Leiferman, 2006; Weinberg &

Tronick, 1998). These areas include parental compliance with anticipatory guidance recommendations, mothering, socio-emotional behavior, and receipt of health care.

Anticipatory guidance. The American Academy of Pediatrics has made several anticipatory guidance recommendations for parents of children ages birth to 1 year. These recommendations are aimed at maintaining optimum health of children and include breastfeeding, putting the infant to sleep on its back, putting the infant to sleep while it is still awake, refraining from putting the infant to sleep with a bottle, and engaging in positive interactive activities with the infant (Paulson, et al., 2006). Postpartum depression is one factor that may prevent parents from following these recommendations.

Paulson et al. (2006) examined the extent to which postpartum depression among parents "influences their engagement in parenting behaviors that are consistent with anticipatory guidance recommendations and that have been associated with a stable household environment and child well-being" (p. 661). The researchers found moderate to severe depression in 14% of mothers and 10% of fathers in the study group. Mothers and fathers were least likely to follow anticipatory guidance recommendations if both were depressed. Depressed mothers were less likely to put their infants to sleep on their backs, less likely to have breastfed their infants, and more likely to put their infant to bed with a bottle. Positive interactive activities with the infant were more likely if neither parent was depressed. When one parent was depressed, the nondepressed parent was less likely to engage in play activities with the infant. However, the child was more likely to be put to bed awake when one or both parents were depressed.

Mothering. Logsdon et al. (2006) pointed out that an infant's primary caregiver is usually its mother. Thus, the first memories of infants often involve the mothers (Logsdon et al., 2006). Statistics, however, indicate that many infants experience less than nurturing mothering. Evidence suggests that postpartum depression can severely impact the mother-infant bond as well as the infant's social and cognitive development (Seyfried & Marcus, 2003)**.** Stressors such as depression can have a negative impact on mothering. Postpartum depression is an important contributing factor to ineffective mothering (Seyfried & Marcus, 2003).

Logsdon et al. (2006) conducted a study, the purpose of which was to "define the specific components of the maternal role and describe the impact of postpartum depression on each component of the role" (p. 652). Logsdon et al. (2006) identified four components of mothering: interacting with the infant; performing caretaking tasks; promoting the health and development of the infant; and finding pleasure and gratification in the mothering role. The researchers explained that, through the interaction with the mother, the infant develops knowledge and skills and becomes familiar with the external environment. If the interaction is optimal and the mother is successful in accomplishing the caretaking tasks, the mother's confidence in her role as a mother will be increased (Logsdon et al., 2006). However, due to the labor-intensive nature of caretaking, the mother's level of stress may be increased (Logsdon et al., 2006). According to the researchers, providing for the infant's health and development can also be stressful for the mother as this mothering component can also be labor-intensive and requires that the mother have planning, decision-making, and time management skills

(Logsdon et al., 2006). Furthermore, the researchers argued, although most mothers find pleasure and gratification in the mothering role, those who experience depression find less pleasure and gratification in the role (Logsdon et al., 2006).

Socioemotional behavior. It is believed that infants as young as 3 months old are aware of their mothers' depression as these mothers interact with their infants differently than do nondepressed mothers (Weinberg & Tronick, 1998). Infants whose mothers are depressed have problems with social, cognitive, and emotional functioning (Weinberg & Tronick, 1998). These problems tend to persist as the infant advances in age (Weinberg & Tronick, 1998). Depression in childhood and later years is not uncommon as these infants get older. The researchers examined "the relation between women self-reported functioning and direct observations of maternal and infant socioemotional behavior in a group of mothers" (p. 1300) being treated for postpartum depression. To evaluate this difference, mother–infant interactions were videotaped and the mothers' self-reported functioning was measured using several tools. A group of mothers without evidence of depression served as control. In the presence of postpartum depression, the researchers found that both mothers and infants had compromised socioemotional functioning although the mothers received treatment and reported feeling well. There was also evidence that the mothers' self-reported evaluations were discordant with their behaviors.

Weinberg and Tronick (1998) also evaluated the interaction of strangers with the infants. The researchers found that the unbiased stranger was more likely to have positive interactions with infants of nondepressed mothers. Strangers were less likely to be

engaged in their interactions with infants of depressed mothers. The researchers concluded that infants of depressed mothers "brought something to the interaction that served to compromise their interactions with individuals other than their mothers" (Weinberg & Tronick, p. 1302). The researchers concluded that the infants "emotional reactivity" (Weinberg & Tronick, p. 1302) may further compromise the negative interaction with the mothers and further reinforce the mothers' negative self-perception.

Receipt of health care. Minkovitz et al. (2005) evaluated the association between the frequency with which children received health care services and maternal depressive symptoms experienced when children were 2 to 4 months old and 30 to 33 months old. The study population was a cohort of mothers from 15 Healthy Steps for Young Children sites across the United States. The researchers hypothesized that reported maternal depression symptoms were associated with decreased receipt of preventive care and increased receipt of acute care. Mothers who reported depressive symptoms were more likely to be young, nonwhite, Hispanic, unmarried, and possessed less than high school education. The researchers found that, children aged 2 to 4 month old received less preventive services and were more likely to have emergency department visits if their mothers had depressive symptoms. There was no association found between receipt of health care services and maternal depressive symptoms for children in the 30 to 33 months age group. However, the findings indicated that mothers who reported symptoms of depression when their infants were 2 to 4 months of age were less likely to complete the telephone interview when their infants were 30 to 33 months.

Although not a statistically significant finding, Minkovitz et al. (2005) observed that 2- to 4-month-old children of postpartum depressed mothers had increased hospitalizations. Maternal postpartum depression may be exacerbated or lengthened because of the infant's poor health and the burden of caring for an ill infant (Ueda, Yamashita, & Yoshida, 2006).

Screening

The potential for significant negative impact if postpartum depression is not identified and treated in a timely manner is well recognized (Beck, 2006). To facilitate early identification and treatment of postpartum depression, several health professional organizations have issued guidelines or recommendations for screening women for postpartum depression. In 2006, the American College of Obstetricians and Gynecologists Committee Opinion issued a practice bulletin recommending that women be screened for psychosocial risk factors including perinatal depression. The American Academy of Pediatrics in its delineation of the pediatricians' scope of practice has included the "assessment and consideration of parental and environmental factors that may affect children's health" (Chaudron, Sgilgyi, Campbell, Mounts, & McInerny, 2007, p. 124).

Chaudron et al. (2007) pointed out that the child is the pediatrician's patient. However, they further noted that there are variables, not intrinsic to the child, which can have a negative impact on the well-being of the child and about which pediatricians should be aware. Maternal mental health is one such variable. Chaudron et al. argued that in clinical practice and various studies, the *DSM-IV-TR* definition of postpartum

depression is too narrow in both its application and its timeframe. The authors noted that there is indecision concerning the application of the United States Preventive Services Task Force (USPSTF) recommendation for routine screening to postpartum depression and to pediatric practice. They noted that the burden of the disease; the availability of an inexpensive, safe, simple, valid, and reliable tool; and the existence of effective treatment options are considerations in determining whether or not postpartum depression meets the criteria for such routine screening.

The likely impact of postpartum depression should be considered in determining the need for routine screening. Maternal depression not only impacts child development but also use of pediatric health care services (Chaudron, Kitzman, Szilagyi, Sidora-Arcoleo, & Anson, 2006). To aid in developing guidelines for screening, Chaudron et al. investigated the natural course of postpartum depression among a sample of low-income women. The study methodology was a retrospective analysis of pediatric medical records. The authors selected a limited sample of 67 women with two completed EPDS during well childcare visits. New onset postnatal depression was determined by an initial score of 10 followed by a later score of 10 or greater. One quarter of the women developed a high level of depression after the first 3 months postpartum. Based on this finding, Chaudron et al. concluded that a significant number of cases of possible clinical depression would remain undiagnosed if screening occurred only at the 2-week and 2-month well childcare visits. Findings also suggested that new cases developed throughout the first year postpartum. Screening at each pediatric visit during the first postpartum year may therefore be prudent (Chaudron et al., 2006). The researchers found that, although

the women were reportedly being treated during the study, 25 % of them had consistent levels of depression throughout the first year postpartum. The researchers viewed this as further evidence of the need for additional screening. Because maternal records were not reviewed, the researchers could not determine the effectiveness of treatment. However, they noted that depressive symptoms decreased in 40 % of the women who had been diagnosed with postpartum depression.

Several screening tools are available to help health care professionals screen for postpartum depression and numerous studies have been conducted to test their validity and reliability (Gjerdingen & Yawn, 2009). These screening tools are, however, not without controversy. Paulden, Palmer, Hewitt, and Gilbody (2009) conducted a systematic review of various screening tools and created a model, in the form of a decision tree, to determine their economic costs and associated health outcomes. The researchers used a hypothetical population of women as their study participants. Of the screening methods reviewed, the EPDS was determined to be the most cost effective. However, the researchers found that the EPDS was less cost effective than routine care in which no formal questionnaire was used. The researchers noted that the cost of treating women who received a false positive with formal screening added to the cost of health care and therefore they concluded that formal identification methods did not appear to represent a value for money.

Georgiopoulos, Bryan, Wollan, and Yawn (2001) evaluated the rates of diagnosis and treatment for postpartum depression in the first postpartum year before and after implementation of routine screening with the EPDS. Three hundred and forty-two women

who received care in a community postnatal care clinic were included in the study. Half of the women (171) had EPDS scores indicative of postpartum depression. They were matched based on age with 171 women with EPDS scores not suggestive of postpartum depression. Although the EPDS indicated that 171 of the women were possibly depressed, upon follow up evaluation by a clinician, only 68 were diagnosed as clinically depressed. The study found an associated more than twofold increase in clinical diagnosis of postpartum depression with routine screening with the EPDS when compared to the rate of diagnosis before the screening tool was used. The researchers concluded that such routine screening may be associated with increased diagnosis and treatment.

Gjerdingen and Yawn (2009) conducted a literature review focused on "the recognition of postpartum depression through depression screening, current screening practices and methodologies, and barriers to postpartum depression screening and treatment" (Gjerdingen & Yawn, 2009, p. 281). The authors observed that there is a paucity of published literature "on patient outcomes with screening for postpartum depression" (Gjerdingen & Yawn, 2009, p. 281). The literature review demonstrated the importance of screening. The authors cited several studies that pointed to the devastating and widespread impact of postpartum depression. The authors examined a number of reviews of screening tools and concluded that further studies with "large, representative samples are needed to help identify the ideal postpartum depression screening tool" (Gjerdingen & Yawn, 2009, p. 285); a tool that is short, easy to use, has a good specificity and sensitivity, and has a positive impact on clinical outcomes.

Gjerdingen and Yawn (2009) identified the mothers' follow-up postpartum visit and the infants' pediatric clinic visit as opportune times for postpartum depression screening. Well child care visits, they argued, "provide a convenient longitudinal opportunity" (Gjerdingen & Yawn, 2009, p. 283) for screenings at regular periods throughout the first year postpartum. Further, in their literature review, they found an increase in the likelihood in identifying postpartum depression if screenings are done at postpartum and well childcare visits.

Gjerdingen and Yawn (2009) categorized barriers to screening and treatment as patient-centered, physician-centered, and system related. Patient-centered barriers included social stigma, lack of access to health care, issues with insurance coverage, failure to adhere to treatment regimen and follow-up, and time constraints. The reluctance on the part of some pediatricians to perform screenings of mothers was one physician-centered barrier to screening. Lack of education regarding postpartum depression, unfamiliarity with screening tools, inadequate training, inexperience, managed care policies, and fear of negative legal consequences were identified as other physician-centered barriers to screening. In addition, the demand on the pediatricians' time and the fact they are unaccustomed to caring for adults or to providing mental health care were identified as factors that hindered screening. Systems related factors included "infrequent follow-up visits for mothers, lack of objective, proactive monitoring of recovery, and separation of primary care and mental health services" (p. 285). The authors echoed the USPSTF recommendation of conducting routine depression screening in practices that have mechanisms in place for accurate diagnosis, effective therapy, and follow-up. They

also recommended further studies with representative and ample sample sizes to identify an ideal screening tool.

Treatment Modalities

Postpartum mood disorders are often under diagnosed and inadequately treated (Suri & Altshuler, 2004). According to Suri and Altshuler (2004), contributing factors to this under-recognition and under-treatment included the lack of education of pregnant women about the possibility of postpartum mood disorders, the similarity of some symptoms of these disorders to common postpartum symptoms, and the embarrassment that some women felt about seeking professional help for the less than positive emotions they feel at a time when they are expected to be joyous. A variety of treatment approaches have been employed in the battle against postpartum depression. Treatment modalities may be pharmacological, nonpharmacological, or both. Researchers have evaluated various aspects of the treatment process and modality for postpartum depression.

Beck (2002) described five theoretical perspectives of postpartum depression and the resultant treatment modalities of each. The five theoretical perspectives are the medical model, feminist theory, attachment theory, interpersonal theory, and self-labeling theory. Beck argued that the successful intervention for postpartum depression involved early initiation as well as individualizing the intervention to each mother's particular depressive symptomatology. Beck pointed out that the medical model has been, for nurses and physicians, the predominant theoretical perspective. In this model, postpartum depression is viewed as a medical disorder resulting from individual pathology such as

biochemical or hormonal imbalance. Little thought is given to social, economic, and other potential contributing factors that are extrinsic to the individual. The treatment approach is geared towards biological change within the individual and usually requires prescribed medication.

In feminist theory, postpartum depression is viewed as the result of broader socioeconomic, political, and cultural issues (Beck, 2002). Feminist writers oppose the medical model and assert that the medicalization of childbirth is a likely contributor to the risk of postpartum depression (Beck, 2002). Proposed interventions based on feminist theory involved giving voice to the mother, validating her experiences, and reinforcing her sense of personal power (Beck, 2002).

From the perspective of attachment theory, postpartum depression is believed to result from a dysfunctional relationship between the mother and her partner (Beck, 2002). The mother, Beck noted, perceives her partner as emotionally remote and unsupportive to her attachment needs. The focus of treatment is on the mother and her partner and is aimed at resolving the marital discord (Beck, 2002). If the husband or partner fails to participate in the therapeutic intervention, individual therapy or interpersonal therapy is employed (Beck, 2002).

Interpersonal theory is another theoretical framework on which postpartum depression treatment is based (Beck, 2002). This perspective views humans as social beings whose interpersonal interactions impact their personalities (Beck, 2002). If these interpersonal interactions are negative, they can be anxiety producing and can result in postpartum depression (Beck, 2002). Interventions based on this theoretical perspective

are focused on interpersonal relationships and are collaborative efforts between the mother and therapist (Beck, 2002).

Postpartum depression, viewed from the self-labeling theoretical perspective, is seen as a violation of social norms and expectations surrounding childbirth (Beck, 2002). The mother has discordant feelings towards childbirth and motherhood resulting in a depressive state (Beck, 2002). The mother is aware of the incongruity between her feelings and society's expectations of normal motherhood and this leads to shame, guilt, and an acknowledgement of mental illness (Beck, 2002). Because the mother recognizes her mental distress, she voluntarily seeks help for her disorder (Beck, 2002). Interventions based on this theoretical perspective involve psychotherapy and/or self-help groups (Beck, 2002).

Beck (2002) argued that one is not necessarily bound to a single perspective and that combined interventions may prove more beneficial than a specific treatment modality. Further, mothers should be helped to make informed treatment decisions and referred to a health care provider with the necessary skills set to address their needs (Beck, 2002). Clinicians, Beck suggested, should tailor the appropriate treatment options to each mother's individual needs.

Pearlstein et al. (2006) conducted a 12-week pilot study the goal of which was to examine factors governing the treatment choice of women with postpartum depression. The participants were 23 postpartum women with healthy infants and a clinical diagnosis of major depression. The women were given a choice of three treatment options: sertraline alone, interpersonal psychotherapy alone, or a combination of sertraline and

interpersonal psychotherapy. The women were informed of the risks and benefits of each treatment option including the possible risks and effects of exposing breastfed infants to sertraline. Two study participants chose sertraline alone, 11 chose interpersonal psychotherapy alone, and10 chose a combination of sertraline and interpersonal psychotherapy. Factors influencing treatment choice were time constraints, breastfeeding, and previous history of depression. The two women who selected sertraline alone did so because of time constraints that prevented them from committing to the weekly sessions needed for psychotherapy. Of the12 study subjects who were breastfeeding, a majority (66.7%) chose interpersonal psychotherapy alone. Most of the women (85.7%) with previous histories of depression selected a treatment option that included sertraline. The researchers performed a baseline assessment at the start of the study to assess the women's level of depression. Measurements done at the end of the 12-week study period showed significant decrease in the women's level of depression. Based on this finding, the researchers concluded that all three treatment approaches were effective in treating postpartum depression.

Murray, Cooper, Wilson, and Romaniuk (2003) evaluated the effect of three psychological interventions on mother-infant relationships and child outcomes. The study sample consisted of 193 women diagnosed with postpartum depression. The women were randomly assigned either routine care, or one of three psychological treatments; nondirective supportive counseling, cognitive behavioral therapy, or a brief psychodynamic psychotherapy. Treatment took place in the home from eight to 18 weeks postpartum. Assessments of the women and their children were done before initiation of

treatment and then at specific intervals (4 and 1/2 months, 18 months, and 60 months) after treatment. Trained individuals with no knowledge of the specific treatment group to which the women belonged performed the assessments. At 4 and 1/2 months, assessments of early management of infant behavior, early problems in the mother-infant relationship, and mother-infant interaction were conducted. The treatment impact on early management of infant behavior was insignificant in all treatment groups. Early mother-infant relationship problems were significantly decreased for women receiving psychological treatments. Women receiving routine care reported minimal reduction in mother-infant relationship problems. The evaluation of mother-infant interaction showed that three psychological interventions also resulted in increased maternal sensitivity. At 18 months, the assessments focused on later infant behavioral and emotional problems, infant attachment, and cognitive development. Later infant behavioral and emotional problems were less in the three psychological treatment groups compared to the routine care group. For all treatment groups, there were no major treatment effects and scores were comparable for both infant attachment and cognitive development. Emotional and behavioral problems and cognitive development were assessed at 60 months postpartum. No major treatment effects were observed for all four treatment groups. The researchers observed that early intervention provided short-term favorable effects on maternal-infant relationship and child outcomes but that such favorable effects did not persist. Further, the researchers concluded that more prolonged interventions may result in more sustained benefits.

In their study, Horowitz and Cousins (2006) evaluated the rates of treatment at 3 and 4 months for women identified as having postpartum depression symptoms at 2 to 4 weeks postdelivery. Of the 1,215 women from a community-based population who were screened, 122 women with symptoms of postpartum depression were identified and 117 of the 122 completed the study. Horowitz and Cousins (2006) found that at 3 and 4 months, just 14 (12%) of the women received psychotherapy. Even less received medication: four (3.4%) at 3 months and seven (6%) at 4 months. Horowitz and Cousins observed that women with high levels of postpartum depression were more likely (23.3%) to receive psychotherapy than those with low levels of postpartum depression (8.1%). Possible determinants of the low treatment rates were personal factors such as fear of stigmatization, limited insurance coverage, and system issues related to the health care system and provider.

Treatment Decisions

Health care providers are encouraged to involve patients, including those with mental illness such as those with postpartum depression, in decisions about their care so that their perceived needs may be addressed. Terry (2007) noted that over the last one-third of a century there has been a change in the clinician-patient relationship from paternalism to an equal partnership. That is, previously physicians were seen as paternalistic in their relationship with patients. Despite this change, elements of paternalism can still be seen in health care and in some instances may be perceived as justified (Buchanan, 2008). Buchanan observed that because the discipline of public health is focused on the health of populations rather than the health of individuals, some

have argued that the identification of when paternalism is justified is a major distinguishing issue between clinical ethics and public health ethics. Buchanan argued that this focus on identifying an ethically acceptable justification for paternalism in public health is misguided because the predominant cause of morbidity and mortality is chronic rather than infectious diseases. Chronic diseases such as hypertension are typically viewed as resulting from lifestyle choices, whereas infectious diseases such as typhoid and other contagious diseases are less associated with lifestyle choices and, without decisive action, can quickly devastate a population. Buchanan further argued that a focus on expanding autonomy rather than seeking to justify paternalism, would better serve the interest of public health.

Buchanan (2008) distinguished between weak paternalism and strong paternalism. Proponents of weak paternalism believe that paternalistic interventions are ethically sound in situations where people have impaired decision-making powers and are likely to engage in activities that are likely to result in harm to themselves (Buchanan, 2008). On the other hand, those who support the use of strong paternalism maintain that such paternalism is justified even when people have fully functional decision-making powers (Buchanan, 2008). Buchanan suggested that some federal research, geared at weak behavioral interventions, is based on the view that unhealthy behaviors result from "irrational and pathological factors (peer pressure, dysfunctional family dynamics, internalized oppression, etc.)" (p. 17) given that such unhealthy behaviors are not in an individual's best interest. Because some perceive unhealthy behaviors to be irrational, those who support the use of weak paternalism see ethical justification for behavioral

interventions that involve such paternalism (Buchanan, 2008). Buchanan argued that there is no ethical or empirical justification for paternalistic interventions. He pointed to research that demonstrated that individuals who are allowed the greatest degree of autonomy have the best health while those with the least degree of autonomy have the worst health. Buchanan therefore recommended that public health should focus on enhancing rather that limiting individual autonomy.

Buetow (2005) argued that of the different types of clinician-patient interactions, only interactions in which the clinician and the patient contribute or coprovide is there real care. In coprovision, clinicians provide clinical expertise and patients provide expertise on "their bodies, life situations, values, beliefs, and preferences" (Buetow, p. 554). Buetow pointed out that clinicians and patients enable each other therefore each has the power to "clarify role ambiguities, negotiate difference of interest, and act in their own capacity" (p. 554). Coprovision, as a model of care, allows for mutual participation but does not demand equality (Buetow, 2005). Buetow noted that equality is not always desired or may not be achievable. Buetow argued that other models of care such as paternalism or consumerism give more control to one party than the other and is therefore not true care. Paternalism is believed to be disempowering, undermines patient responsibility, and hinders care (Buetow, 2005). Consumerism also hinders care, and minimizes and devalues the role of the clinician (Buetow, 2005).

Deegan and Drake (2006) observed that the current management of chronic medical illness involves a shared decision-making process. Further, they argued that this high standard of care should be employed in the management of psychiatric illness. Self-

determination and empowerment are basic values that are of great importance to the physically and mentally disabled and are values a shared decision making process supports (Deegan & Drake, 2006). Deegan and Drake examined the shared decision-making process from the perspectives of the client and the practitioner. In particular, they focused on the use of shared decision making in medication management for individuals recovering from mental illness. Shared decision-making recognizes the expertise of the client and the practitioner and requires that they agree on treatment goals and the path to accomplishing such goals (Deegan & Drake, 2006). They argued that medical paternalism fails to acknowledge the important role the client has in the selection of a treatment plan and assigns blame to the client who fails to follow the practitioner's directives. Medical paternalism is perceived to be unethical unless employed in an emergency where the client has no decision-making capacity and no surrogate decision maker or advance directives (Deegan & Drake, 2006). Terry (2007) pointed out that a surrogate does not always act in the patient's best interest and that it may be necessary to call upon the ethics committee and/or court to appoint someone to protect the interests of the patient.

As noted earlier, there has been a shift from paternalism to an equal partnership in the clinician-patient relationship. At the core of this partnership is the view that patients and their values should be respected if good medical care is to be attained (Terry, 2007). However, Terry pointed out that a physician may influence a patient's decision through rational persuasion, coercion, or manipulation. Rational persuasion involves presenting the patient with factual information. The patient makes a decision based on the

logic of the facts and along with his or her values. Coercion involves a threat and having the ability to carry out the threat. The physician who manipulates the patient's decision does so by selectively "emphasizing or deemphasizing some information inappropriately" (Terry, 2007, p. 566) so that the patient will view the physicians choice as the most appealing. Rational persuasion is the only ethical way of influencing a patient's decision and is used in the process of obtaining an informed consent (Terry, 2007). As Terry pointed out, patients do not always want to make a decision by themselves and should be asked how and who they wish to decide rather than what they wish to decide. Terry also highlighted the need for health care providers to be culturally competent when engaged in obtaining an informed consent. Terry advocated employing the informed consent process for "even the most mundane of patient-physician interaction, that of writing a prescription" (p. 567).

Research Methodology

Much of the literature on postpartum depression that I identified and reviewed for this study reported results from quantitative research. I found less qualitative research on the issue of postpartum depression. As Trochim (2001) pointed out, there has been debate in the scientific community concerning the supremacy of one research method over the other. Proponents of quantitative research contended that their data type was "hard, rigorous, credible, and scientific" (Trochim, 2001, p. 11). The response from supporters of qualitative research was that their data were "sensitive, nuanced, detailed, and contextual" (Trochim, 2001, p. 11). Trochim viewed this dispute as counterproductive. Trochim pointed out that quantitative data and qualitative data are interconnected.

Further, Trochim argued, "all quantitative data is based upon qualitative judgments and all qualitative data can be described and manipulated numerically" (p. 11). Babbie (2004) observed that there is widespread recognition of the contribution of both approaches. Some have used a mixed-method approach by combining both qualitative and quantitative methods in their research (Trochim, 2001).

Quantitative research is described as a recognized, objective, methodical process to explain and measure associations, and to investigate causal relationships among variables (Burns & Grove, 2001). Quantitative data and quantitative variables are expressed numerically and quantitative data are said to be "confirmatory and deductive in nature" (Trochim, 2001, p. 158). Babbie (2004) observed that, on one hand a quantitative approach allows for ease in aggregating, comparing, and summarizing the data, on the other hand, there is a "potential loss in the richness of meaning" (p. 26).

Qualitative research is a methodical, interactive, subjective process that describes and gives meaning to life experiences (Burns & Grove, 2001). Qualitative data and qualitative variables are not expressed numerically, but rather in text, pictorial, audio, or other forms (Trochim, 2001). Trochim described the nature of qualitative data as "exploratory and inductive" (p. 158). According to Jejeebhoy (2005), the qualitative approach can highlight:

> underlying behaviors, attitudes, and perceptions that determine health outcomes; it can help us explain social and programmatic impediments to informed choice or the use of services; it can shed light on the success of our interventions; and it can

> facilitate better understanding of the policy, social, and legal contexts in which health choices are made (p. xix).

Researchers have used various research methodologies to explore postpartum depression. Quantitative researchers have focused on issues such as, but not limited to, forms of the disorder and its prevalence among various groups of women (Dietz et al, 2007; Georgiopoulos et al., 2001); its etiology and duration (Chaudron, et al., 2006; Serretti, Olgiati, & Colombo, 2006); rates of identification and treatment; (Horowitz & Cousins, 2006; Murray, Woolgar, & Cooper, 2004); and efficacy of various treatment modalities (Marcus et al., 2001; Misri et al., 2000; O'Hara et al, 2000, Pearlstein et al, 2006). Qualitative researchers have explored women's explanations of postpartum depression (Ugarriza, 2002), their explanation of the reality of the postpartum period (Edhborg et al., 2005), their experience with seeking care (Sword et al., 2008), as well as other issues. Some researchers, such as Brockington, McDonald, and Wainscott (2006), have used mixed methods to further understand postpartum depression.

No study that explored women's lived experiences of the screening and treatment process was found in the literature. Specifically, in this study I sought to describe women's experiences of the screening and treatment process for postpartum depression and to determine their view of the adequacy of the screening and treatment process. The focus of the study was the women's subjective experiences. Thus, I chose the phenomenological approach, which centers on the subjective experiences of individuals, for this study.

Trochim (2001) described several qualitative approaches. These include ethnography, field research, grounded theory, case study, and phenomenology.

The ethnography approach is employed when a whole culture is the focus of the study (Trochim, 2001). For a study focused on describing postpartum depression within a particular culture, an ethnographic approach may prove effective. When the goal of the researcher is to observe the phenomenon of interest in its natural environment or state, field research is used (Trochim, 2001). The literature has not identified a natural state or environment for postpartum depression and it was not my goal in this study to investigate postpartum depression in any particular state or environment; the field research approach was therefore not effective for this study. The grounded theory approach is used to develop theory about the phenomenon being investigated (Trochim, 2001). Grounded theory would have been effective if the goal was to develop theory. Trochim defines a case study as an in-depth investigation of a particular individual or perspective. Further, Babbie (2004) noted that "the limitation to a particular instance of something is the essential characteristic of the case study" (p. 293). The case study approach could effectively illuminate the experience of an individual. However, this approach was not chosen because my concern for this study was not a particular individual or occurrence of a phenomenon. Phenomenology focuses on individuals' subjective experiences and perspectives (Trochim, 2001). Lopez and Willis (2004) described two phenomenological approaches; transcendental or descriptive phenomenology and hermeneutic or interpretive phenomenology. Researchers use the transcendental phenomenology approach to examine phenomena as "perceived by human consciousness" (Lopez &

Willis, 2004, p. 727). Moustakas (1994) referred to transcendental phenomenology as Husserl's phenomenology and noted that the only data obtainable to the consciousness is used in transcendental phenomenology. The description rather than the explanation of the phenomenon is sought. Hermeneutic phenomenology focuses "on what humans experience rather than what they consciously know" (Lopez & Willis, 2004, p. 728). Hermeneutic phenomenological can illuminate aspects of the experience of the phenomena that may be beyond the level of consciousness and may therefore identify elements "that might have direct relevance to practice" (Lopez & Willis, 2004, p. 734). For this study, I chose the hermeneutic phenomenological approach because in this study, I sought to inform practice through the focus on the subjective experiences and perspectives of women who have been screened and treated for postpartum depression.

Summary and Conclusions

Postpartum depression continues to be a major health problem that deprives many mothers of the joys of motherhood. Research has indicated that there are several biological and psychosocial factors that are believed to cause postpartum depression. In discussing the three conditions generally known as postpartum depression, Seyfried and Marcus (2003) noted that the etiology continue to be a mystery.

The literature review showed that postpartum depression impact on the mother, her partner, and offspring can be severe. For mothers, postpartum depression makes motherhood and the adjustment to parturition very challenging (Edhborg, et al., 2005; Landy, et al., 2009). The mother's interaction with her partner and infant can also be severely impacted (Edhborg et al., 2005). Fathers must also adjust to fatherhood. Their

adjustment and their relationship to mother and infant can be negatively influenced by postpartum depression (Condon, 2006). For infants, postpartum depression can adversely affect parental compliance with anticipatory guidance recommendations (Paulson, et al., 2006), mothering (Logsdon, et al., 2006), socio-emotional behavior (Weinberg & Tronick, 1998), and their receipt of health care (Minkovitz, et al., 2005).

To effectively manage postpartum depression, timely identification and treatment is essential. The American College of Obstetricians and Gynecologists and the American Academy of Pediatrics are among professional organizations that have developed guidelines for screening women for postpartum depression. Several tools have also been developed to aid screening. Researchers have evaluated the effectiveness of screening tools and identified barriers to timely screening of women for postpartum depression (Gjerdingen & Yawn, 2009).

There are varied pharmacological and nonpharmacological treatment modalities for postpartum depression. Beck (2002) identified several theoretical perspectives of postpartum depression and concomitant treatment modalities. In discussing these perspectives and related treatment approaches, Beck concluded that one is not necessarily constrained by a single perspective and that an approach that combines two or more treatment modalities may be more effective than a single treatment modality. In decisions around treatment, consideration must be given not only to the various approaches to treatment but also to the mothers' needs (Pearlstein et al, 2006) and the mother' involvement in the decision-making is encouraged. Involving mothers in treatment

decisions to address their postpartum depression fosters the empowerment process which serves to enhance wellness, self-esteem, and autonomy (Chambers & Thompson, 2008).

In this study, I used empowerment theory to develop the interview questions with the aim of understanding the participants' perception of the screening and treatment processes for their postpartum depression. The literature review presented no information on women's view of the screening and treatment processes. In this study, I aimed to fill this gap by employing a hermeneutic phenomenological approach to study the issue. As previously stated, I chose the hermeneutic phenomenological approach because my aim in this study was to inform practice. A description of the study methodology or approach as well as the researcher's role is presented in Chapter 3.

Chapter 3: Research Method

Introduction

For many mothers, the birth of a child brings emotional turmoil and great distress rather than joy and happiness. The reason these women experience such emotional distress is that they suffer from postpartum psychiatric mood disorders, commonly called postpartum depression. There are three well-known postpartum psychiatric mood disorders. The first is called "baby blues," maternity blues, or postpartum blues, and it is experienced by some 50% to 85% of new mothers (Advances in Neonatal Care, 2003). The second is called postpartum depression and occurs in 8% to 15% of new mothers (Advances in Neonatal Care, 2003). The third and most severe form is called postpartum psychosis and affects 1 to 2 women per 1,000 deliveries (Advances in Neonatal Care, 2003). Postpartum psychosis is a psychiatric emergency that requires immediate hospitalization and treatment. Morris-Rush and Bernstein (2002) noted that women experiencing postpartum depressive symptoms often have delusions that their baby is demonic or dying.

In this study, I sought to understand the lived experiences of the screening and treatment process for women with postpartum depression and whether or not these women perceived that their emotional needs were adequately met. Therefore, a hermeneutic phenomenological approach was chosen. Van Manen (1990) described hermeneutic phenomenology as "a human science which studies persons" (p. 6). The goal was to examine that which is unique to individuals rather than that which is generalizable (van Manen, 1990). Data were gathered through in-depth interviews, and the data or text

were then examined for themes (van Manen, 1990). According to Moustakas (1994), hermeneutic phenomenology involves a process through which the researcher corrects or sets aside his or her prejudices and biases and pays attention to the text. Moustakas called this the hermeneutic circle and noted that "prejudgedments are corrected in view of the text, the understanding of which leads to new prejudgements" (p. 10). Further, through "refleective interpretation" of the text, the researcher achieves a more meaningful description (Moustakas, 1994, p. 10) and interpretation of the experience being investigated.

Research Design and Rationale

I used the hermeneutic phenomenology research methodology in conducting this study. The goal was to understand the lived experiences of the screening and treatment process for women with postpartum depression and whether or not these women perceived that their emotional needs were adequately met. Thus, the hermeneutic phenomenological approach was chosen. Two primary research questions were addressed. First, what is the lived experience of the screening and treatment process for women with postpartum depression? Second, to what extent do these women perceive that their emotional needs have been met during their initial postnatal visit and beyond?

The data collection method in phenomenological research is typically through long interviews in an "informal, interactive process and utilizing open-ended comments and questions" (Moustakas, 1994, p. 114). The data collection method was individual, face-to-face, in-depth interviews. This allowed me as the interviewer to probe further into answers that the participants gave. Participants were asked open-ended questions.

Questions included main questions, probes, and follow-up questions as indicated. Rubin and Rubin (2005) suggested formulating four to six main questions. They pointed out that the researcher may or may not use all main questions and cautioned against inserting one's own "understanding or examples in presenting a main question" (p. 157) if respondents are slow in responding to the question. Probes may be verbal or nonverbal and are used to elicit clarification, fill in gaps, and maintain focus on the topic. Rubin and Rubin also warned against probing everything lest one lose sight of the main point, disrupt the course of the interview, and irritate the interviewees. I asked follow-up questions if there were indications that relevant information were missing or if I needed further depth and understanding of a main point. The main interview questions appear in Appendix B. The questions were constructed using the empowerment theory (Hur, 2006; Perkins & Zimmerman, 1995; Peterson, et al., 2005) and aimed at obtaining information on components of empowerment theory as well as the participants on perception of the screening and treatment processes for their postpartum depression.

To enhance the accuracy of the data collection, interviews were audio-taped and handwritten notes were also taken. Rubin and Rubin (2005) noted that written notes serve not only as a backup but compel the researcher to be attentive. Further, I was attentive to nonverbal cues as these served to alert me to areas that required further probing or to emotions that could indicate areas of sensitivity that required changing the line of questioning.

Before each interview, I prepared mentally by acknowledging and reflecting on any biases and preconceived thoughts about postpartum depression and on what the

participants may or may not disclose. According to van Manen (1990), "our common sense, pre-understandings, our suppositions, assumptions, and the existing bodies of scientific knowledge, predispose us to interpret the nature of the phenomenon before we have even come to grips with the significance of the phenomenological question" (p. 46). Van Manen argued that researchers must first "make explicit our understandings, beliefs, biases, assumptions, presuppositions, and theories" (p. 47). In transcendental phenomenology, the researcher would then bracket or set aside these biases and preconceived notions. Bracketing is a process of cleansing of the consciousness in which the researcher reserves "prejudgments, biases, and preconceived ideas about things" (Moustakas, 1994, p. 85). However, in hermeneutic phenomenology, self-reflection brings such biases and preconceived notions to the fore but they are not bracketed to the same extent as required in transcendental phenomenology, but are given consideration and are included in the data interpretation (Laverty, 2003). According to van Manen, while there is an attempt to hold assumptions, biases, and presupposition in abeyance, there is also an effort to "turn this knowledge against itself, as it were, thereby exposing its shallow or concealing character" (p. 47). I maintained a detailed journal of my thoughts, feelings, and reactions during the interviews and analysis process. I added these journal entries to the data and included them in the interpretation.

Role of the Researcher

The researcher is important to the research process. As Babbie (2004) pointed out, the researcher can cause bias in the tone of the questioning, construction of the questions, and body language. I was careful not to introduce bias into the interview

process through my tone used in asking the questions, verbal language, or my body language. My personal views and experiences could have also biased the research. Richards (2009) argued that bias can be useful in a carefully designed study by taking into account or examining those factors that are already known. The researcher's bias should be addressed in the research design and tested (Richards, 2009). The first step in addressing the researcher's bias, Richards argued, is to acknowledge and openly state that bias.

I am a female, was born in and spent my formative years in the West Indies, and am a nurse whose profession primarily involved caring for critically ill neonates. Later, I was employed by a large public health care corporation as the Assistant Director of the Women's Health Programs in the Quality Management Department. I am now the Associate Director of Quality Management at an acute care facility to which the large public health care corporation is the parent company. I am unmarried and have no children but had a sister-in-law who was the mother of four and who experienced postpartum psychosis. I was in my late teens at the time when my sister-in-law was experiencing postpartum psychosis. It is my view that there was a lack of understanding of my sister-in-law's condition on both the part of professionals and the public and that that lack of understanding led to my sister-in-law being marginalized, abused, and not afforded much support. I believe that the body of scientific literature has led to an increased understanding of postpartum depression. However, I believe that there remains a lack of understanding of the issue as evidenced by literature that showed that postpartum depression has continued to be underdiagnosed and inadequately treated. I

believe that women experiencing postpartum depression should be provided with appropriate treatment. Should failure in timely identification and inadequate treatment result in the mother killing her infant, she should be not be labeled a criminal and face prosecution, but rather be seen and treated as the victim that she is. I am aware of my views and values regarding the issue of postpartum depression but conducted the study with, as Richards (2009) recommended, an open mind. Richards noted that having an open mind is not the same as having an empty mind. I acknowledged my views and values but did not interpret the study findings based on those views and values. The research methodology for this study was hermeneutic phenomenology. While self-reflection and open acknowledgement of the researcher's biases and preconceived thoughts and ideas must be openly acknowledged, the hermeneutic approach does not require bracketing as in transcendental phenomenology (Laverty, 2003).

Methodology

The study participants were women who have had a clinical diagnosis of postpartum depression and have received treatment. Since the onset of postpartum depression is usually a few days to 4 weeks postdelivery (Seyfried & Marcus, 2003) and the first postpartum visit is not until 6 weeks postpartum visit, postpartum depression may not have been identified prior to the sixth postpartum week. Further, Horowitz and Cousins (2006) found low treatment rates at 4 months or less. In this study, my aim was to involve women who had been treated for postpartum depression therefore mothers whose children are older than 4 months old were recruited for participation.

The plan for recruiting participants in this study was to use a purposeful sample of mothers from a postpartum depression support group. The Postpartum Resource Center based in Long Island, New York, is one organization that has a postpartum depression support group. I contacted the staff of the Postpartum Resource Center to discuss the proposed research. I provided the staff with my contact information and asked them to inform potential study participants who express a willingness to be included in the study, to contact me. From this recruitment effort, only four women qualified and agreed to participate. IRB approval was sought to expand recruitment efforts to other women's health clinics in New York City. I asked staff at Caribbean Women's Health Association (CWHA) in Brooklyn, the East Side Women's OB/GYN Associates in Manhattan, Downtown Women OB/GYN Associates, and SoHo Obstetrics and Gynecology Practice in Manhattan to assist with flyer distribution to their clients. I also distributed flyers by hand at laundromats in Brooklyn and front of two daycare centers in the Bronx.

I met with the potential participants individually to discuss the study purpose, criteria for inclusion, confidentiality, informed consent, and their rights as participants including the right to withdraw at any time. I also answer questions or concerns that potential participants had regarding the study. Allowing the participants to ask questions of the researcher not only help in providing clarity about the research but also help in building rapport between the researcher and study participant (Richards, 2009). Additionally, as Richards (2009) pointed out, the questions from potential participants can add to the richness of the data by allowing the researcher to clarify areas of confusion

for the participants and possibly by giving the researcher further insights into the participants' perceptions.

Women who express a willingness to participate in the study were asked to sign a written consent giving permission to be interviewed and allowing publication of their experience at the end of the study. Assurances were given to participants that, while descriptions of their experiences will be published, no identifying information will be included and confidentiality will be maintained. Further, their consent for electronic recording of the interviews was obtained.

Participants consisted of 10 women who had been screened and treated (or are receiving treatment) for postpartum depression. Richards (2009) did not recommend a sample size for qualitative studies and argued that "well-designed qualitative research projects are usually small, the data detailed and the techniques designed to discover meaning through fine attention to content of text of images" (p. 19). Qualitative techniques, Richards observed, require a considerable amount of time and a considerable sample size is not necessary. Creswell (1998) however recommended an upper limit of 10 participants for phenomenological studies.

Participants were women at least 18 years old, who were able to read and speak English, were mothers of one or more children, were 8 months or more postpartum, had received treatment for postpartum depression, and who may or may not have had an ongoing relationship with their partners. Women who have had the least serious of the three postpartum conditions described earlier, postpartum blues, were not included in the study. Postpartum blues requires no treatment and is usually resolved within a few days

(Seyfried & Marcus, 2003). Women experiencing postpartum psychosis were also excluded from the study. Signs and symptoms of postpartum psychosis include distractibility, increased activity, delusions, hallucinations, cognitive disorganization, bizarre behavior, and an inability to function (Seyfried & Marcus, 2003). If a woman was observed to have these signs and symptoms at the time of the study, she would have been excluded and referred to a mental health professional as postpartum psychosis is a psychiatric emergency. The study participants were women who had a clinical diagnosis of postpartum depression, the second of the the three postpartum conditions, and received treatment. To determine whether or not potential participants have had a clinical diagnosis of postpartum depression, I asked the potential participants how the diagnosis was made. Six participants reported being diagnosed and referred by providers for treatment. The remaining four said they sought treatment on their own as they recognized something was wrong and they were unable to cope.

Analysis

Walden University provided IRB approval for the study. The IRB approval number is 05-01-13-0096258. Following IRB approval data collection for the study started. Prior to conducting the actual study, a pilot study was undertaken with two women. The data collection and analysis of the pilot test helped in determining the effectiveness of the data collection process, participants understanding of the questions, openness in answering the questions, and whether or not interview main questions needed to be revised. Data analysis began with the review of the pilot study interviews to determine if any changes were necessary. Through this analysis, I determined that no

change was necessary. As soon as possible after each interview, I transcribed verbatim, audio recordings and notes for each interview. The transcribed data were organized by participant, reviewed for accuracy, and stored electronically. I reviewed the data systematically to identify themes and coded the data using NVivo 9 software.

Interpretation of the data required that the data be coded and analyzed. Two types of coding methods are the inductive or a posteriori method and the deductive or a priori method (Kortendick & Fischer, 1996). The inductive or a posteriori method of coding was employed. Kortendick and Fischer (1996) noted that the inductive or a posteriori method uses the text as the basis for constructing the coding categories. In this method, the researcher isolates the dominant themes in the text and then defines ranges of themes. The inductive approach tends to have a high internal validity because the coding system is close to the text and the research question (Kortendick & Fischer, 1996). I sought clarification of ideas or statements as needed from the study participants.

The inductive coding method was chosen for this analysis over the deductive coding method because, as Kortendick and Fischer (1996) pointed out, the deductive approach requires a prolonged training for the coders to learn the wide range of codes for proper coding of the data. Due to this wide range of codes, the deductive or a priori method has a lower validity than the inductive or a posteriori method (Kortendick & Fischer, 1996). The inductive method is driven by the data and does not require the development of a codebook (Kortendick & Fischer, 1996). The deductive method requires the development of a codebook, hence the need for training (Kortendick & Fischer, 1996). When using the deductive approach, the researcher develops the

codebook a priori based on the research questions and theoretical framework or after a preliminary analysis of the data (Fereday & Muir-Cochrane, 2006).

To facilitate the data analysis, I carefully examined the text to develop themes. The techniques that I employed in identifying themes included listening or looking for interesting or unfamiliar terms used by the study participants (Pope, Ziebland, & Mays, 2002) and listening and looking for word repetitions (Ryan & Bernard, 2003). An additional technique used was constant comparison, which involves the analysis and comparison of each item with the remainder of the data (Pope et al., 2002). Additionally, I used the NVivo 9 qualitative software, developed by Qualitative Solutions and Research International, in coding, indexing, and searching the data. NVivo 9 capabilities include storing, organizing, retrieving, sorting, and searching the data to assist in identifying themes (Richards, 2009). Transcripts of 10 interviews were uploaded into NVivo 9 for coding, categorization, and for analysis for emergent themes. To code the data, I read the transcripts carefully and categorized descriptive statements stored at nodes. Nodes are areas where data segments can be coded and stored for further analysis. Consideration was given to the possibility that one or more cases might not have followed the data trend or, as Creswell (1998) described it, were of divergent perspectives. Freeman, et al. (2007) advised against inadequate analysis of these discrepant cases. I systematically analyzed the data were for discrepant cases and to determine if such cases were truly divergent and to account for such divergent perspectives.

Issues of Trustworthiness

To ensure the trustworthiness of a qualitative study, the demonstration of four elements have been recommended. These elements are credibility, transferability, dependability, and confirmability. Credibility relates to the confidence a researcher has that the phenomena being explored is correctly recorded (Shenton, 2004). Approaches that can assist in establishing confidence include the appropriate selection of the research methodology, sampling method, triangulation, and employing appropriate strategies to ensure that participants provide truthful answers. The selection of a recognized and proven research approach can foster credibility (Shenton, 2004). The hermeneutic phenomenological approach, described earlier in this chapter, is a well-established approach and was selected as the best approach for the design of this study.

Shenton (2004) noted that the use of random sampling of research participants may refute accusations of researcher bias in qualitative studies. In this study, I used purposive sampling. However, while this approach may not ensure the same evenness of distribution of what Shenton refered to as unknown influences, the participants are from diverse backgrounds and thus there is a wide range of informants. Having a wide range of informants is one method of triangulation, another strategy for enhancing credibility. With this method of triangulation, data from one participant can be cross-checked with data from other participants. Shenton observed that, “individual viewpoints and experiences can be verified against others, and ultimately, a rich picture of the attitudes, needs or behavior of those under scrutiny may be constructed based on the contributions and range of people” (p. 66). Similarly, comparing data from participants from different

sites, referred to as site triangulation, may foster credibility (Shenton, 2004). Initially, one site was chosen to assist with recruitment of participants. This yielded only four participants and so IRB approval was sought to expand recruitment to additional sites. An unintended consequence of this expansion of recruitment is the ability to have site triangulation which can enhance credibility.

Credibility can also be assured by ensuring that participants provide honest responses (Shenton, 2004). Strategies include developing a good rapport between research participants and the researcher, giving participants the option to opt in or out of the study, and encouraging participants to be candid in providing answers (Shenton, 2004). I developed rapport with each study participants by meeting each one, describing the study to them, defining my role and purpose, obtaining their consents to involve them in the study, and provide them with the opportunity to opt out of the study at any time. Further, ethical guidelines, outlined further in this section, were also employed to build credibility and to protect the study participants.

The second element of trustworthiness is transferability. This concept concerns the degree to which the study findings can be applied or transferred to others or in other situations. Individual perception of the same or similar phenomenon may differ. Shenton (2004) argued that different inquiries that result in varying results may not necessarily denote that one study is more worthy of trust than another, but may "simply reflect multiple realities" (p. 71). Shenton therefore questioned whether a goal of true transferability is realistic. Perhaps what is more important is accurate reporting of

methods and findings that can allow others to conduct similar investigations in other settings, thus allowing for comparison of findings.

Accurate and detailed reporting of study methodologies allows others to replicate the study. This is the hallmark of dependability, the third element of trustworthiness. Shenton (2004) stressed the need for accurate reporting as a means of assisting others to not only replicate the study and but also to evaluate the degree to which correct research techniques were employed. Further, Shenton noted that the goal of repeating the study may not necessarily be to obtain the same results. As stated earlier, individuals' perceptions and realities may vary, thus even after employing the same research procedures for the same phenomenon at a different time or place may not yield the same results. Other factors, such as researcher bias, can influence the study findings and may in part account for divergence in study findings.

Confirmability, the fourth element of trustworthiness, involves strategies to minimize researcher bias. The goal is to ensure that actions are taken so that reported findings are based on the realities and perceptions of participants and not the inclinations of the researcher (Shenton, 2004). Shenton noted that this is an area in which triangulation can also be of value. Further, the researcher's open acknowledgement of his or her biases is encouraged as a way of furthering confirmability. As with dependability, a detailed description of the study procedures can promote confirmability. In this chapter I have provided a detailed description of the research plan and procedures and a disclosure of my role and biases as well as actions I took to minimize those biases. In Chapter 4, I have provided a more detailed description of the study participants, data

analysis, and study findings. Further I will now outline the steps taken to ensure that the ethical guidelines for protection of participants were followed.

Several ethical standards have been developed to guide researchers and to help in ensuring that research participants are adequately protected. These ethical guidelines include the Nuremberg Code, the Declaration of Helsinki, and guidelines that the World Health Organization and the Council for International Organizations of Medical Sciences published (Hutton, 2001). The IRB approval process ensures that researchers adhere to these ethical guidelines. For this study, I obtained IRB approval from Walden University. The IRB approval number is 05-01-13-0096258.

In designing research involving human subjects, there are several ethical issues that must be considered. These include the issues of informed consent, confidentiality, benefit and risk of the research, recruitment, incentives, and conflict of interest. It is essential that steps be taken to address these concerns so that the research participants and all stakeholders can be assured that the research does not violate any ethical standard. The safeguard of the dignity, safety, well-being, and rights of research participants is recognized as an important role of researchers today. Ethical research includes being truthful to participants about the purpose of the research, maintaining confidentiality, protecting participants emotionally, and respecting the participants (Rubin & Rubin, 2005). Not deceiving interviewees, being honest about the researcher identity and intent, and not promising research benefits that the researcher cannot guarantee or deliver are all ways of demonstrating respect to participants (Rubin & Rubin, 2005). Respect also

involves the manner in which the researcher interacts with participants (Rubin & Rubin, 2005).

This study involved women who experienced or were experiencing postpartum depression. As such, there may be questions regarding their mental state and whether or not their participation was voluntary. Potential study participants were provided with all relevant information about the study that allowed them to make an informed decision about participation. Agreement to participate in the study was voluntary and the study participants were informed of their right to withdraw at any time if they so desired.

Rubin and Rubin (2005) recommended that, if the interviewee appears uncomfortable or stressed because a tough question was raised, the researcher should refrain from pursuing the question. If the researcher considers the question important, the researcher may raise the question later either directly or indirectly (Rubin & Rubin, 2005). Postpartum depression can cause severe emotional disturbances and reliving these emotions might have been difficult for the participants in this research. I made efforts to shield the participants from emotional distress and I would not have pursued questions to which participants exhibited or verbalized discomfort or stress. If a study participant exhibited significant distress because of the study, a referral to an appropriate health care service would have been made. None of the participants exhibited or verbalized such distress.

Study participants were also assured of confidentiality. Participants were afforded the opportunity to select the location for the interviews with some limitations with regard to the maintenance of confidentiality and privacy. This was done to give

them additional control over the interview process. However, I ensured that the locations or spaces in which the interviews were conducted allowed for privacy and confidentiality. Five of the interviews were conducted in the offices where five of the participants worked, three interviews were conducted in my office, one was conducted at a participant home, and one took place in my car. Each interview lasted between 30 minutes and 1 hour. All personal identifiers were removed from the data, and every effort was made to keep the data secure. I ensured that my written notes, electronic recordings, and computer files in which the data are stored are accessible only to me and kept in a locked and secure location.

Researchers must also give ethical consideration to what is reported. Rubin and Rubin (2005) pointed out that researchers must evaluate the potential for harm in what is reported. In this study, I evaluated the relevance of each disclosure as well as likely harm to participants that could result. I did not anticipate that there would be any disclosure that was likely to cause harm but if such disclosures were made, they were not reported.

Summary

Today health care has moved from a paternalistic model of care to a model of shared decision in which the health care provider and client set mutually determined goals (Taylor, 2005). In this research, I sought to determine whether postpartum women perceive that their emotional needs were met during their initial and subsequent postpartum visits. The findings addressed the question of whether or not postpartum depressed women feel that they were adequately screened and treated for postpartum depression. Determinations of how women feel about the screening and care they receive

for their postpartum depression can help plan appropriate screening and care for women with postpartum depression. By understanding how patients view health care and by assessing their level of satisfaction, health care providers can better address the needs of their clients. The findings from this study can then be disseminated and used to plan for the appropriate screening, referral, and care of postpartum depressed women. Findings are presented in Chapter 4 and include discussion of identified themes.

Chapter 4: Results

Introduction

The results of this study are outlined in Chapter 4. In this study, I investigated women's perceptions of the screening and treatment processes for postpartum depression. In-depth interviews were conducted with 10 women who experienced postpartum depression. The plan for this study included recruitment of participants, data collection and storage, data analysis, emergent themes, and summary. NVivo 9 was used to facilitate the data analysis. Specifically, NVivo 9 was used in the storing, organizing, sorting, retrieving, and searching the data to assist in identifying themes. The Postpartum Resource Center, CWHA in Brooklyn, the East Side Women's OB/GYN Associates in Manhattan, Downtown Women OB/GYN Associates, and SoHo Obstetrics and Gynecology Practice were asked to assist with recruitment of study participants.

Pilot Study

Following IRB approval, the initial data collection and analysis for this study began with the enrollment of the first two participants in a pilot study. The purpose of the pilot study was to evaluate the interview questions to determine if changes were necessary. The procedure for recruitment and the interview process were the same for both participants in the pilot study and the participants in the main study. In individual meetings with each participant, I discussed the study purpose, inclusion criteria, confidentiality, informed consent, and the participants' rights, including the right to withdraw at any time. I evaluated the responses the two pilot participants provided to the interview questions during and after the interview to determine if changes to the

questions would be necessary. The participants' responses and reaction to the questions indicated that no changes were necessary.

Demographics

Women who experienced postpartum depression were recruited with the aid of a flyer. The flyer, containing a brief description of the study and my contact information, was sent to the Postpartum Resource Center and was posted to their Facebook page. The Postpartum Resource Center, based in Long Island, provides postpartum depression support and education to at-risk women and families throughout New York State. Initial recruitment yielded only four participants. IRB approval was sought to expand recruitment efforts to other women's health clinics in New York City. Staff at CWHA in Brooklyn, the East Side Women's OB/GYN Associates in Manhattan, Downtown Women OB/GYN Associates, and SoHo Obstetrics and Gynecology Practice were asked to assist with flyer distribution to their client. I also distributed flyers by hand at laundromats in Brooklyn and two daycare centers in the Bronx. Twenty-one prospective participants contacted me and were evaluated for inclusion in the study. I met with each potential participant individually and discussed the study purpose, criteria for inclusion, confidentiality, informed consent, and their rights as participants, including the right to withdraw at any time. Eleven of the 21 women were excluded; of these, five decided to withdraw after hearing the description of the study, five were excluded as they reported experiencing postpartum blues rather than postpartum depression, and one did not follow up after the initial contact to inquire about the study. Ten participants were then included in the study. The first two participants recruited for the study were used in the pilot study

but were ultimately included in the study as the recruitment processes, criteria, and selection process were the same for these participants as they were for the other participants.

The group of 10 participants ranged in age from 28 to 48. Four were African Americans, four had emigrated from the Caribbean, one had emigrated from Latin America, and one had emigrated from the Philippines. The participants were asked to choose a name other than their real names by which I addressed them during the interviews. These chosen names were Tanya, Ann, Hillary, Beth, Nicey, Maggie, Saniyah, Betsy, Amy, and Nonie. Tanya was an administrative assistant with two children. She was separated from her husband and was involved in divorce proceedings. She received pharmacotherapy as well as group therapy for her postpartum depression. Ann, Hillary, Beth, Betsy, and Nonie were health care workers. Ann had one child and was no longer in a relationship with her partner at the time of data collection. She received group therapy for her postpartum depression. Hillary had one child and was living with her husband but wanted a divorce. She sought counselling for her postpartum depression. She had had three failed pregnancies and felt her husband pressured her to get pregnant, blamed her for the failed pregnancies, and was unsupportive. Beth had two children and was in a supportive relationship with her partner. She had a large age gap of approximately 24 years between the births of her two children and reported that she experienced postpartum depression following the birth of her second child but not following the birth of her first child. She received pharmacotherapy and group therapy for her postpartum depression; she was continuing to receive pharmacotherapy at the time of

data collection. Betsy was a single mother of one and received group therapy for her postpartum depression. Nonie was a mother of two with a 15-year gap between her first and second pregnancies. She reported receiving both psychotherapy and pharmacotherapy for her postpartum depression. Like Beth, Nonie reported experiencing postpartum depression following the birth of her second child but not following the birth of her first child. Nonie lived with her husband and children and reported strong family support while experiencing postpartum depression. Nicey was a secretary and a mother of five. She reported that her fifth child was an unplanned pregnancy that occurred when she was 39 years old. She stated that she did not experience postpartum depression with her first four pregnancies. She received psychotherapy for her depression. Maggie became pregnant while in college, had one child, and was not in a relationship with the child's father at the time of data collection. She received group therapy for her postpartum depression and was preparing to resume her college education. Saniyah was a marketing executive and divorced mother with two children by two different fathers. She was not in a relationship with either of her children's fathers. She received both psychotherapy and pharmacotherapy for her postpartum depression. Amy was a housewife and mother of two. She had postpartum depression following both of her pregnancies and received both pharmacotherapy and psychotherapy. Each participant was asked six open-ended questions aimed at addressing the two research questions.

Data Analysis

Ten participants responded to the interview questions in individual, in-depth, face-to-face interviews. The interviews were audio recorded, the recordings transcribed,

and the transcripts imported into NVivo9 for the data to be explored. In coding the data for analysis, the inductive coding method or a posteriori was used. With this approach, the text is used as the basis for constructing the coding categories and involves isolating dominant themes in the text and then defining ranges of themes. Kortendick and Fischer (1996) noted that the inductive method is data driven and thus does not require the development of a codebook. The data were first explored for word frequencies and common ideas. Text and matrix coding were also done. Coding of the data involved reading the data transcripts, identifying descriptive statements, and categorizing the data into nodes. Within NVivo 9, nodes are areas where reference material can be categorized and stored for further analysis. The node categories included emotion and feeling, coping, behavior, assessment, understanding and support, and praying. After the analysis of all the transcripts, six major themes emerged. The themes were as follows: crying and stress during and after pregnancy; inadequate assessment; feeling bad or unlike oneself; lack of understanding; needing to cope; and prayer was essential for recovery. No discrepant cases were identified. The theme of crying and stress during and after pregnancy emerged from the node category of emotion and feeling, which had subnodes of stress, crying, and emotion. Inadequate assessment was the theme that emerged from the assessment node, which had a subnodes of provider discussion. From the behavior node, the theme of feeling bad or unlike oneself emerged. This theme had subnodes of unusual actions, strange thoughts, and odd feelings. The theme of lack of understanding was associated with the understanding and support node, which had subnodes of family support and health care provider support. The coping node had subnodes of desire for relief,

treatment, and actions to reduce stressors. Prayer was essential for recovery was the theme that emerged from the prayer node.

Evidence of Trustworthiness

Efforts were made to ensure objectivity in data collection and analysis. The key to this process is trustworthiness elements, which include credibility, transferability, dependability, and confirmability. To establish credibility, I provided the participants with information regarding the study and allowed them to ask me questions about the study before agreeing to participate. Further, I assured the participants of the privacy of their information and allowed them to choose private and secure areas for the face-to-face interviews. The initial interviews were conducted in venues that the participants chose. This provided a sense of control to the participants and ensured that they were in a place where they felt secure. I also evaluated the areas that were chosen to ensure that their privacy would be maintained. Follow-up phone calls were made to nine of the 10 participants to ensure the study results' objectivity. This process of follow-up with participants or member checking to review the transcripts and interpretation is another strategy for ensuring the quality of the evidence. Shenton (2004) described member checking as "the single most important provision that can be made to bolster a study's credibility" (p. 68). Member checking also helps to ensure dependability as it allows for participants to validate that the researcher accurately reflected and interpreted their words. Transcripts and findings were reviewed with nine participants to ensure the accuracy of the data and to discuss the data interpretation. The tenth participant could not be reached.

In conducting the follow-up phone calls, I also asked the participants whether their locations allowed for privacy and completed the calls following assurance of privacy. Feedback from the participants indicated that their words were accurately reflected and interpreted. There was no disagreement from any of the participants as to the interpretations and findings.

To assure transferability, dependability, and confirmability, I provided a detailed description of the study procedures including but not limited to the participant recruitment process, the data collection process, data storage and analysis, and the study's findings. This will help the reader to determine the appropriateness of the research techniques and to evaluate the trustworthiness of the study.

Results

The data analysis of the transcripts resulted in the identification of six major themes. The themes that emerged were: crying and stress during and after pregnancy, inadequate assessment, feeling bad or unlike oneself, lack of understanding, needing to cope, and prayer was essential for recovery. A discussion of each of these themes follows.

Crying and Stress During and After Pregnancy

Participants were asked to describe the emotions they experienced during their pregnancies and in the early weeks following the births of their babies. All participants reported crying and feeling sad, stressed, anxious, or down during their pregnancies. Their crying and anxiety intensified following the births of their babies, which added to the feeling of being overwhelmed. The study participants often did not understand the

reasons for their tearfulness. However, they described having some uncertainty regarding childcare, the future of their babies, and the responsibility of being a mother that may have exacerbated their feelings of sadness, depression, and increased levels of stress. It is likely that the sadness and tearfulness these women experienced were the results of their uncertainty and concerns about their roles as mothers and the future of their children. Below are excerpts of the responses from three participants.

> Ann: During my pregnancy the initial emotion, I cried a lot. I felt lonesome, alone by myself. I felt isolated, lonely, isolated, betrayed. When the baby was born I had feelings of ambivalence. I was excited and happy but at the same time sad. My emotion was like a wave. One moment I was happy, one moment I was down and sad, one moment I would look at her and see joy, and then a next moment I would look at her and worry in concern about her life.
>
> Hillary: During the pregnancy I was, no I was very, I was kind a stressed, you know, during the pregnancy. Not because of the pregnancy but because of the problems that I had while I was pregnant. So that during the course of the pregnancy, you know, I got very depressed, cry, sad, because, you know, when you are pregnant for the first time you go through so many problems….crying in and out. Yeah, a lot of crying and hollering, you know. Oh Jesus, mercy; after the baby was when the crisis really begins.
>
> Saniyah: I still like cry randomly. I am super emotional. I cry at like commercials. Like…like…it's like, you know, I probably should be on medications; probably.

Inadequate Assessment

Seven of the participants felt that they were not properly assessed for their postpartum depression. They reported that they did not recall being asked about their mental state. This finding is significant as the literature review identified an inadequacy of screening and treatment as a potential factor in the worsening of some women's postpartum depression (Dietz et al., 2007; Miller, 2002; Seyfried & Marcus 2003). Tanya reported going to the emergency room several times before her postpartum depression was diagnosed and treatment initiated. Ann had a caesarean section and stated that her health care provider's main focus was her incision. In describing an encounter with her doctor, Ann said:

> He basically assessed my incision, called me mom, and that was it. There wasn't any further question. Although he was my doctor, but he checked me out he examined me, he checked my incision, because I had a cesarean section. So he saw my incision was fine. The wound was healing wonderfully and everything, to him, looked good, so he was fine with it, and assessed me about pain and that was it.

The women's description of their postpartum visits to their doctors suggest that providers were more concerned about the physical well-being of mothers and their babies and did not adequately assess their mental health or mood. By not assessing the mental health of women during and after their pregnancy, interventions for depression during and after pregnancy will not be timely and can result in worsening of depression. Even for women experiencing the blues, early recognition and support is important. As Suri

and Altshuler (2004) noted, reassurance and support are needed for women experiencing the blues, as some 20% of these women will progress to postpartum depression.

Three participants admitted being asked about their feelings and moods initially but did not tell their provider what they were experiencing. Beth first stated that the doctor did not assess her. She then admitted that she held back and was not very forthcoming about her feelings when her doctor asked her what was "going on". Nicey and Nonie also admitted to not being forthcoming when discussing their feelings with their doctors initially. Beth stated:

> Well they did not really assess me at that time. Not really, because I wasn't—I would like hold everything in, you know. I wouldn't tell them how I was feeling. My doctor, he was a good doctor. He looked at me and he said, "Beth something is going on." And I just kept denying it saying I'm fine, I'm fine, and he said, "You're not fine, something is going on." And I kept telling him, "I am fine, nothing is going on." But then eventually I just couldn't hold it in anymore.

Some participants spoke of their reluctance in disclosing to their health care providers a disturbance in their mental state. This reluctance to disclose may have hampered the screening and treatment process for these women. A factor for these participants reluctance to disclose is that they did not want to be viewed as bad mothers. Betsy said, "I wasn't interested in being with my baby. I was not really happy and to me that—I thought that was not normal. That was being a bad mother and I did not want to be seen as a bad mother".

Feelings Bad or Unlike Oneself

Eight participants recalled unusual behaviors, feelings, and desires. They recalled not feeling like themselves and engaging in behaviors or having thoughts that they knew were somewhat bizarre but not being able to control the behavior. Participants also reported being unable to effectively manage routine daily tasks. The following excerpts, from two participants, documents some of the behaviors and thoughts experienced.

> Ann: There were periods of time that I could be in the bathroom combing my hair and I would get these waves within me and the wave would be of disgust, rejection, or worthlessness. Thank you God, that's the word I want, worthlessness. So I would be combing my hair and all of a sudden I just start pulling real quick, hard, or rake my hair hard in the mirror just combing it and getting an urge within myself if I had some scissors; that kind of mind set. If I had scissors, I'd just cut, just cut it off and there was nothing wrong with my hair. It was just, I could be combing it getting ready to go somewhere, but for an immediate moment in the mirror, I would get this wave and I would feel a surge, and when I feel the surge is like a…where it makes you grit your teeth, that kind of, you know, and then I just and soon as I react to it whether it's to comb my hair or sometimes I would have, I would yell. I would just scream out for no reason. And often times when I would do that my mother would be like, "Why are you, what is the matter? Why are you hollering like that? You in pain? Something is wrong? What, something frightened you?" And I would be like, "No I just need to release something."

> Beth: I would wake up in the middle of the night, four o'clock in the morning and I would just want to leave the house. I would just, I would put on my clothes and my baby father would wake up and he is like, "What's wrong? Where you going?" And I said, "I got to go, I got get out, I got to get out, I got to get of here." It was like I don't know where I was going but I just had to get out the house. And, I would call my mom and he called my mom and he said, "She want to get out of the house. I don't know what to do if she wants to get out the house." …… I would jump up I would get up; feel like I had to leave the house. Three and four o'clock in the morning and that's when my, my, my son, my son had to come stay with me. Everybody was staying with me. My mom, everybody; because they know like in the middle of the night I would get up and if nobody would see me I would be out in the street.

Participants were unable to explain their unusual behaviors. The women were aware that their behaviors were bizarre but to them the cause was not clear. Furthermore, the women felt powerless as they could not control the behavior and did not want to be seen as being crazy. This inability to control their behavior disrupted their lives and the lives of their loved ones and added to their stress.

Lack of Understanding

Participants described a lack of understanding that was twofold. First, participants described having lack of understanding of postpartum depression and therefore a lack of understanding of what they needed to discuss with their health care provider. Ann said:

> I also was very quiet. I would only answer a question if asked. I was not a person that asked many questions. As long as everything was ok for what I went to them for, then I didn't ask any questions outside of that. So if I am there and he is going to check my incision, then he is going to check my incision; and the incision is ok, it is ok so that's about it. Regardless of what I am thinking in my head and what I may be feeling, in my mind I am here for this doctor for this so this is what I am going to, you know, discuss with him. I won't introduce anything else outside of that. One because of fear of not understanding what the problem was, really. That I was going through because I had no idea what was happening so there was no question to ask, 'cause I knew no question to ask.

Nicey and Amy reported having limited discussions about postpartum depression during their pregnancy but still reported a lack of understanding. Others reported not having any information and felt that this lack of information and understanding contributed to their anxiety. While Beth also felt that she had very little understanding of what she was experiencing, she believed that her health care providers provided her with an explanation of what she was experiencing. An excerpt from Beth's response is documented below.

> About how I was feeling? Um, I asked him why was I going through this. Why is this happening to me, you know, and he explained it to me….he was telling me about women go through this postpartum thing, especially women who had kids late in life, you know. He said not that I was that old but I did have beyond child bearing years. So, he was like it's just, it's, it's….here is something that women

> go through. He explained it to me to the "T" but I can't remember everything because another, my memory is like, there is a lot of things I can't remember.

The second aspect of this lack of understanding is that these women also felt misunderstood by health care providers and sometimes friends and family. For health care providers that failed to diagnose, perhaps this lack of understanding was due to an uncertainty of what to do. In their study, Chew-Graham, Sharp, Chamberlain, Folkes, and Turner (2009) found that some providers had difficulty ascribing a label of postpartum depression when the only treatment they could offer was referral to another provider. Similarly, family and friends may have had difficulty supporting these women because they did not understand and were not sure what to do. Hillary said:

> Then when my husband call and I am crying nobody seem to want to investigate and want to find out why I'm crying and then if I cry he said he is gonna leave me because he can't be bothered; he's gonna leave me because I am crying, you know.

Needing to Cope

Participants stated the difficulty they had coping with the discordant feelings their experience of postpartum depression caused. Four participants, Ann, Hillary, Saniyah, and Maggie, felt that their needs were not addressed, and, needing to find ways to cope, they sought treatment on their own. They recognized that something was wrong and desired to be well but felt unable to resolve the problem on their own. Saniyah reported requesting admission to a hospital and later receiving pharmacotherapy. She

stated “I self-admitted.” Maggie spoke of eventually going to a provider and telling him of the difficulty she had coping. She stated,

> I told him I was feeling overwhelmed that I was having a hard time caring for the baby and that I did not think I was going to be able to cope. I was afraid that I would harm the baby. No…no I did not want to harm him but I…I…I just did not feel comfortable caring for him.

Tanya also reported needing to cope and making repeated visits to the emergency room. Beth spoke of feeling lonely and unable to cope with the world and in order to cope was willing to do whatever was necessary. She stated,

> I know in order for me to get better I had to do what I had to do and all these things, um, um, participating with everything I had to, to incorporate myself into all this in order for me to get better. So anything that I had to do, anything that they told me to do, or whatever, I did you know, because as they say everything that I am doing here is to help me. So I’m.…my level of participation….any time they said, “Beth, you have to do this, you have to do this.” I would be ready because my goal was to get better and go home. That’s what I wanted to do, and in order for me to do that I had to participate I had do what I have to do to make myself better so that’s what I did. I participated, I did whatever I had to do and, um, every time my baby would come see me, that would be even a more determination to just get better and go home. So I’m, I, I participated in everything whatever they wanted me to do I did and I’m glad I did because it brought me to the level where I’m at now. I’m, I can go back to work, I can, I was

able to go back to work. I was able to, to, to just be in society and just be around people, you know, wherein I couldn't do that before, you know, but now, I think it was good.

Prayer was Essential for Recovery

The prayer theme had references from eight participants. These participants felt a need for and sought divine intervention. They did not feel that psychotherapy, group therapy, and/or pharmacotherapy were adequate to address their needs. Statements from three of these participants are recorded below.

Hillary: I remember one morning I got up and I started to sing and I was praying because I was praying for God to help me just to let this feeling go so I could start having a connection with this kid, you know. 'Cause my husband at one time was fearful that I was going to kill the baby. I wasn't going to kill the baby but I did not want to be around the child fearing that I would harm the child. Yes. I was afraid…I believe in God; I'm a Christian, right, and I believe that there is something. After a while I started thanking God for, you know, just for letting something happen.

Ann: So for me, personally, for myself I had to deal with my own storm, my own personal storm. I had to become a born again. I had to ask God to help.

Nonie: But you know something, there must be a high, high, high correlation between um…um…it's more effective…religion is more effective to medication. Because I was on it (medication) for like 6 months and um…I'm ok but um…I still don't want to take care of her until I began to…to um…to go to synagogue.

Summary

In this chapter, I describe the process used for data collection storage, analysis, and verification. The results are presented within the context of the central research questions. The themes that emerged from the responses were crying and stress during and after pregnancy, inadequate assessment, feeling bad or unlike oneself, lack of understanding, needing to cope, and prayer was essential for recovery.

These findings were reviewed via follow-up phone calls with the participants. Nine participants were available for the follow-up phone calls and agreed with the results. The tenth participant could not be reached.

In Chapter 5, I will present an interpretation of the study findings, implications for social change, recommendations, and the conclusion. An explanation of the findings potential to promote positive social change as well as advance exploration of postpartum depression will be included.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

In this hermeneutic phenomenological study, I sought to gain insight into the lived experiences of the screening and treatment processes for women who experienced pospartum depression. Specifically, I investigated their perceptions of the adequacy of the screening and treatment they received. Two research questions guided this study: What is the lived experience of the screening and treatment process for women with postpartum depression? and To what extent do these women perceive that their emotional needs have been met during their initial postnatal visit and beyond? Ten participants were recruited for inclusion in the study. In individual in-depth interviews, the participants described their experiences of postpartum depression, how their depression was identified or diagnosed, and the treatment received. The interview questions were developed based on empowerment theory. Six themes (crying and stress during and after pregnancy, inadequate assessment, feeling bad or unlike oneself, lack of understanding, needing to cope, and prayer was essential for recovery) emerged from the responses to the interview questions. Nine of the 10 participants participated in follow-up phone calls to ensure the study results' objectivity and accuracy. The tenth participant could not be reached.

Interpretation of Findings

The findings of the research revealed that the participants in this study did not believe that the screening and treatment processes for their postpartum depression were adequate, and they therefore also did not feel that their emotional needs were addressed in a timely manner. They spoke of the stress they experienced, their difficulty coping, and

the crippling impact it had on their daily lives. For women, the experience of postpartum depression causes great distress and makes motherhood a far less than joyous experience (Advances in Neonatal Care, 2003; Beck, 2006). All of the participants reported crying during the pregnancy and noted that the crying intensified in the postpartum period. This was consistent with Seyfried and Marcus's (2003) description of mood lability and feelings of hopelessness that women experiencing postpartum depression exhibit.

The participants also spoke of exhibiting bizarre behaviors that left them feeling unlike themselves. This was similar to the finding of Edhborg et al. (2005) that showed mothers felt a loss of their physical and emotional selves. They also reported difficulty performing routine tasks. One participant reported being ashamed of having visitors in her home as her depression caused her to neglect the performance of daily housekeeping chores.

Further, as Edhborg et al. (2005) observed, some mothers reported that the fathers were supportive while others felt that there was increased misunderstanding and lack of support from the fathers. Findings in this study paralleled those in the Edhborg et al., study. Two of the 10 participants said very little about their partner's support, four described their partners as supportive, and the remaining four described their partners as not helpful or supportive. At the time of data collection, six of the women in this study had separated from their partners. Two, Hillary and Saniyah, reported verbal abuse by their partners during and after pregnancy. Saniyah reported the following:

> I met a guy, started dating for like 8 months, I get pregnant. He wants to get me pregnant as he says repeatedly. I get pregnant; not on purpose. Took the Plan B

> pill after we had sex; didn't work I was pregnant either before …it got there …before I got the pill or whatever. So um…you know, he sort of went crazy. Like one minute. "I love you"; next minute "I hate you. I want you to die". He went on Instagram…Twitter talking crazy about me like that I'm this and I'm that. So it was really a hard pregnancy.

Gjerdingen and Yawn (2009) noted the importance of screening in the identification of postpartum depression and discussed opportune times for screening. They also categorized barriers to screening. In this study, a barrier to screening was the reluctance of several of the participants to disclose to health care providers the mood disorders they were experiencing. Chew-Graham et al. (2009) noted that some women cite their own barriers as well as characteristics of their health care providers as factors that inhibited their willingness to disclose. They did not want their health care providers to view them as incompetent mothers and trigger a social service investigation or have their children taken away (Chew-Graham et al., 2009).

In visits to their health care providers, several of the participants felt that these providers were not concerned with the emotional discordance they were experiencing. They believed that their health care providers were primarily concerned with their babies. Seven of the study participants reported feeling that their postpartum depression was not properly assessed and treatment was therefore delayed. One participant repeatedly went to the emergency room and four other participants had to seek treatment on their own as they found their symptoms worsening and becoming increasingly intolerable. As Dietz et

al. (2007) and Miller (2002) noted, the consequences of untreated postpartum depression can be long-term and the consequences can be shattering.

Participants in the study also reported a lack of understanding of what they were experiencing as well as a lack of understanding of what they needed to discuss with their health care providers. This finding was parallel to the observation of Suri and Altshuler (2004) that a contributing factor to the underrecognition and undertreatment of postpartum depression included a lack of education of pregnant women of the likelihood of postpartum mood disorders and the embarrassment some women felt about seeking professional help. Additionally, the findings suggested that health care providers, family members, and others did not understand these mothers, and this may have resulted in a lack of timeliness of screening and treatment as well as lack of social support.

Limitations of the Study

An important limitation to this study was the difficulty in recruiting participants who were trusting and willing to share their experiences of postpartum depression. Individuals experiencing mental disorders often have fears about being labeled as "crazy." Horowitz and Cousins (2006) noted that some women fear stigmatization and that this fear may influence treatment rates. It is possible that such fear also influences participation in studies of women experiencing postpartum depression. Twenty-one women contacted me and were evaluated for inclusion in the study. Eleven were excluded from the study for reasons noted previously. The five that withdrew had concerns about their interviews being recorded. My assurances of privacy and

confidentiality were not enough to convince these five participants to trust me with keeping audio recordings of their experiences.

A second limitation to this study is that findings cannot be generalized. This study provided some understanding into some women's experience of postpartum depression. The findings were specific to the women in the study and could not be generalized to all women experiencing postpartum depression. Further, while the study participants were diverse, some racial or ethnic groups were not represented. No conclusions or generalizations can be made about the experience of postpartum depression in women whose racial or ethnic groups were not represented in this study.

Recommendations for Further Study

In this study, I addressed the experience of the screening and treatment processes for the 10 study participants. Although postpartum depression has been recognized as an issue since days of Hippocrates (Miller, 2002), there has continued to be a lack of understanding surrounding the issue. Given this lack of understanding, there needs to be further study into the screening and treatment processes and strategies for getting women appropriate care for their postpartum depression. Study participants lacked insight into the issue of postpartum depression and could likely have benefited from an in-depth discussion of postpartum depression before and during their pregnancies. These women's partners could have also benefited from information and discussion of postpartum depression before or during the women's pregnancies. A lack of understanding on the part of the women's partners could possibly explain lack of partner support and the abuse that some women experienced. Research on the impact of prepregnancy and prenatal

postpartum depression education on women's understanding of and willingness to disclose their postpartum depression is needed. Additional research on the issues of partner support is warranted.

The women in the study spoke of being stressed and described some events that contributed to this stress. Further research into the relationship between stressful life events and social support is also needed. This could greater illuminate the impact of these issues on women's experiences of postpartum depression and help in efforts to minimize the impact of postpartum depression. Logsdon et al. (2006) noted that mothers may experience stress related to the labor-intensive nature of caring for their infants. However, there are other life events that serve as stressors and should be considered in future research.

Because a significant limitation in this study was the difficulty in recruiting participants, research into barriers and strategies for recruitment of participants, particularly those with mood disorders or other mental health issues, is needed. Findings from such research could help researchers in planning for recruitment of participants.

Implications for Social Change

The responses of women in this study indicate that they experienced emotional distress and struggled to cope with the feelings they experienced. The assessments of their mental states during their pregnancies and after the births of their babies were inadequate. There was also a lack of support from their providers and at times from family members. Positive social change implications of this study are that the findings can be used to assist women's health providers in understanding the experiences of the

postpartum depression that some women may have so that appropriate and timely care can be provided. This understanding should cause them to seek to educate women and their families about postpartum depression, and to help in widen public knowledge of the struggle that these women and others like them may face. The findings can also serve to alert health care providers to factors that should be considered in the screening and treatment processes for postpartum depression. These factors include a deficit in knowledge of postpartum depression that some women may have and the difficulty some have in disclosing their feelings to providers. Study participants reported a lack of understanding of postpartum depression. This lack of understanding contributed to the difficulties the participants had articulating what they were feeling in their encounters with their health care providers. Insights gained from this study can be used to heighten awareness and assist health care providers in planning appropriate screening and in meeting the individual needs of women with postpartum depression.

Technology can be used to assist providers in the screening process as well as in educating women about postpartum depression. The electronic medical record is being used increasingly in health care settings. Screening tools and reminder prompts can be built into the electronic medical records that will ensure that clinicians screen women for and educate women and their families about postpartum depression.

Inadequate assessment was a finding of this study. Study participant Hillary stated, “Assessment is important. They need to assess what is going on in the family and sometimes individual assessment on both persons.” Several health professional organizations have provided guidelines for screening women for postpartum depression.

A 2006 practice bulletin from the American College of Obstetricians and Gynecologists Committee Opinion recommended screening women for psychosocial risk factors including perinatal depression. The American Academy of Pediatrics included in its pediatricians' scope of practice a recommendation that consideration be given to parental and environmental factors that may impact children's health (Chaudron et al., 2007). Postpartum depression is one such factor that may have a negative influence on children's health. While these recommendations or guidelines are available to providers, the experiences of the study participants would suggest that the guidelines are not consistently followed. Followings these guidelines could aid in timely assessment and treatment a therefore could potentially benefit women like the participants in this study.

The findings of this study should be disseminated to the multidisciplinary group of reproductive health care professionals such as obstetricians, pediatricians, OB/GYN and pediatric nurses, social workers, and family planning providers. These individuals can use the findings to help in guiding their practice around postpartum depression in educating, screening, and treating women who may experience the disorder.

Researcher's Reflections

As stated in Chapter 3, I am a female who was born and spent my formative years in the West Indies. I began my career as a nurse in the West Indies. Much of my career was spent caring for critically ill neonates. Over the last several years I have been employed in quality management, first as the Assistant Director of the Women's Health Programs in the Quality Management Department of a large public health care corporation and currently as the Associate Director of Quality Management at one of the

corporation's acute care facilities. I am unmarried and have no children. My experience of postpartum depression has been vicarious. I had a sister-in-law who was the mother of four and who experienced postpartum psychosis. I have also cared for mothers who have experienced postpartum depression, yet, I was somewhat surprised at the depth of emotions expressed by the women in this study and the courage they demonstrated in telling their stories.

A strong influence in my choosing postpartum depression for my research, is the unjust persecution by the justice system of some women that committed infanticide while experiencing postpartum depression. The tragic consequences these women experienced, I believe, occurred because they were not given the support and understanding they needed. As I listened to the study participants, I realized that, had they not entered into treatment, I could have been listening to their stories in the news media rather than talking to them in person.

Despite the common themes identified in this study, I marveled at the unique experiences of each woman. I also marveled at the fact that, despite postpartum depression being recognized centuries ago, the growth of the body of scientific literature that has led to an increased understanding of postpartum depression, and screening recommendation from several health care professional organizations, the disorder continues to be under-diagnosed and inadequately treated. I continue to believe that women should be screened to determine if they are experiencing postpartum depression and that appropriate treatment should be provided. I also continue to believe that when the failure to identify and treat these women in a timely manner results in a mother killing

her infant, she should not be prosecuted and labeled a criminal. Rather, she should be viewed as the victim that she is and provided treatment.

Conclusion

The findings of this study indicate that the participants felt that the screening processes for their postpartum depression were inadequate and this resulted in a delay in treatment. Several participants, in order to cope, sought treatment on their own. Participants also experienced increased crying and stress during and after their pregnancy. Several experienced bizarre behaviors and thoughts, and felt a lack of understanding and support. Timely assessment and treatment might have helped to lessen the distress these women experienced. One factor that delayed assessment in some of the participants was their hesitancy to inform their providers of their distressed moods and difficulty coping. Provider education about this factor should be emphasized and strategies developed to help them in encouraging women to disclose.

The impact of postpartum depression goes beyond the mothers and is shared by their children, their partners and other family members, and society as a whole. This far reaching impact of postpartum depression makes it a significant public health issue. Timely screening and appropriate treatment can reduce the negative impact of postpartum depression. It is hope that providers will use findings from this study to help in strengthening their practice of caring for women who could potentially have similar experiences as the women in this study.

Pinpointing the cause of postpartum depression remains a challenge. However, with screening and appropriate treatment, the suffering and negative consequences of this

disorder can be minimized. With greater understanding, prevention of these consequences may even be possible. Those caring for the mother infant dyad must ensure that their practice is guided by the literature and available guidelines. Further, they must provide individualized care that addresses the needs of each mother based on her unique circumstances and experience.

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Appendix A: Consent Form

Informed Consent

Dear Potential Volunteer

My name is Gloria Watson and I am a doctoral student at Walden University. I am conducting a research study designed to examine women's experiences of the screening and treatment process for their postpartum depression. I am inviting you to participate in the study because you have been identified as having postpartum depression and have been a member of a postpartum depression support group. Before agreeing to participate in this study, please read this form and ask any questions you have regarding the study.

Background Information

The purpose of this study is to determine the extent to which postpartum women perceive that their emotional needs have been met during their initial postnatal visit and beyond and to describe their experiences of the screening process and treatment of their postpartum depression. It is hoped that this study will result in a greater understanding of women's views of the screening and treatment process and that this understanding will help health care providers to meet the needs of women experiencing postpartum depression. Further, this study may heighten public awareness of postpartum depression as a public health problem and result in efforts at prevention.

Procedure

If you agree to participate in this study, you will be asked to:

- Sign this Consent Form

- Make up an anonymous name for yourself and allow me to address you by that name during the interview.
- Participate in an interview of approximately 1 hour.
- Allow me to have tape recorded as well as written documentation of the interview.
- Review what I have written about your interview make sure it is correct.
- Allow me to publish what I have written about your interview once you have ensured that it is correct (no names or identifying information will be included).

Voluntary Nature of the Study

The decision to participate, or not, is yours. You and your decision will be respected whether or not you decide to participate. If you decide to participate in the study now, you can still change your mind at any point in the study. If you feel stressed during the study, you can stop at any time. You may refuse to answer any questions that you feel are too personal, painful, or that you simply do not wish to answer.

Risks of Being in the Study

When recalling or talking about stressful experiences, a person may have uncomfortable feelings. There is a small risk that you will have some uncomfortable feeling during your interview. I will refer you to a professional counselor if you become stressed and feel that you need someone to talk to about your feelings. No other risks of being in the study have been identified.

Benefits of Being in the Study

The study will provide you an opportunity to talk about your experiences during the screening and treatment process for your postpartum depression. You may feel some level of satisfaction knowing that the information you share may benefit others in the future.

Confidentially

I will not use anything that will identify you in the documentation or reporting of this study. Any information that you share that you wish to remain confidential and out of the documentation of the study will be kept confidential.

Contacts and Questions

If you have any questions or concerns during your participation in the study, you may contact me at _____

I will provide you with a copy of this form for you to keep.

Statement of Consent

I have read the above information. I have received answers to any questions I have at this time. I am 18 years of older and I consent to participate in the study.

Participant's Printed Name _____

Participant's Signature _____

Researcher's Signature _____

Appendix B: Interview Questions

Main Interview Questions

1. Describe the emotions you experienced during your pregnancy and in the early weeks after your baby's birth.
2. Tell me about your experiences when you visited your doctor /health care provider after the birth of your baby. How did doctor /health care provider assess your mood or mental state?
3. What questions did your doctor/ health care provider ask about how you were feeling?
4. What did your doctor/ health care provider say/do about how you were feeling?
5. What are your thoughts about the discussion your doctor/ health care provider had with you about how you were feeling?
6. How would you describe your participation in the screening and treatment decision for how you were feeling?