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Assessment and Treatment of Postpartum Depression among Mothers in Imo-State, Nigeria

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MSN/MHA, University of Phoenix, 2011

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Dissertation Submitted in Partial Fulfillment

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Abstract

Postpartum depression affects many postpartum mothers. When postpartum depression is not timely assessed, identified, and treated, it can lead to problems with mother child bonding and cause family problems, negligence, and infant death. The purpose of this phenomenological study was to understand Imo State women's lived experiences and perception on sufficiency of the assessment and treatment received for their postpartum depression. The conceptual theory for this study was the empowerment theory. In-depth, face-to-face interviews were conducted to examine 10 Imo State postpartum mothers' lived experiences of assessment processes and to understand if their psychological desires were addressed. The interviews were audio recorded and notes were taken; the recordings were transcribed, and the transcripts were imported into NVivo9 for the data to be examined. The inductive coding method was used in data coding. The text was used as the source for coding, and the dominant themes were isolated and a range of themes were defined. The themes that appeared from the participants' responses were tearful and anxiety during and after pregnancy, inadequate assessment, stress, lack of knowledge, coping mechanisms, herbalist, and prayer. The participants stated that feelings of unhappiness and sadness increased after delivery of their babies, which were misinterpreted by family and friends. Participants stated that they sought recovery through prayer and herbs. The findings from this study can be used to promote positive social change by enhancing Imo State women's awareness on postpartum depression and also to support health care providers in designing relevant assessments and providing care for women with postpartum depression.

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Chapter 1: Introduction to the Study

The delivery of a child is often associated with excitement and joy, and the new mother is expected to happily welcome her new responsibility. For some mothers, however, this new responsibility not an enjoyable experience because of postpartum depression. There are three circumstances that are termed postpartum depression: postpartum or "baby" blues, postpartum depression or postpartum nonpsychotic depression, and postpartum psychosis (Miller, Kroska, & Grekin, 2016). These three conditions are differentiated by their duration and level of severity. The first condition, postpartum blues, occurs in as many as 50% of mothers, and researchers have described it as a transient mood disturbance (Miller, Kroska, & Grekin, 2016). The symptoms generally resolve within a few hours to a few days, and no treatment is required (Klainin & Arthur, 2009). The symptoms of postpartum blues generally resolve within a few hours to a few days and no treatment is required. Emotional instability and unhappiness are the predominant symptoms. Postpartum depression, the second condition, affects more than 15 % of mothers (Center for Disease Control and Prevention [CDC], 2012). Symptoms include lack of sleep, loss of appetite, lack of concentration, feelings of ineffectiveness as a mother, and suicidal ideation. Symptoms usually last for several weeks to several months and require treatment (Klainin & Arthur, 2009). If it is not treated, postpartum depression can have long-term and devastating consequences (Dietz et al., 2007). Postpartum psychosis is a psychiatric emergency. Symptoms include delusions, hallucinations, and suicidal and homicidal thoughts (Klainin & Arthur, 2009). As Miller

(2016) 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 of the Study

Postpartum depression is often not recognized or under recognized and not treated or ineffectively treated. Postpartum depression is defined as a major depressive illness with onset within the first 4 weeks after childbirth. Miller (2016) observed that hormonal changes occurring within the first few weeks following delivery were a predisposing factor for postpartum depression. Miller noted that tragic familial events related to postpartum depression have resulted in increased public awareness of the pervasiveness of the disorder. Almond (2009) noted that family incidents associated to postpartum depression have resulted in increased public awareness of the disorder. Dietz et al. (2007) assessed the incidence of postpartum depression before pregnancy, prenatal, and postnatal amongst 4,398 women and found that 678 were depressed at some point before, during, or after pregnancy. Mental health disorders specific to pregnancies were identified in 11.8 % of the women (Dietz et al., 2007). Of those who were identified as depressed before pregnancy, 54.2 % also experienced depression during or after pregnancy (Dietz et al., 2007).

Depression occurs more during the postnatal period than the prenatal period due to the added burden of meeting the needs of the infant. Buist (2006), however, argued

against “placing the infant as the cause of the problem” and warned practitioners to be aware that the onset of unhappiness and worry often associated with pregnancy (p. 671). 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 interventions that are caring and nonjudgmental and that are targeted to address the needs of both the mother and infant. Effective pharmacological as well as nonpharmacological treatments are available for managing postpartum depression.

Postpartum depression needs to be addressed early to prevent or minimize its harmful consequences. The costs of untreated postpartum depression can be harmful 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 high among these women. Consequently, early screening, identification, and intervention are essential to the wellbeing of the mother, infant, and family. The U.S. Department of Health and Human Services (2010) set a developmental goal in the Healthy People 2010 objectives of recognizing the medical as well as the mental health complications that may impact labor, delivery, and the postpartum. Postpartum depression has continued to have an impact on the health and wellbeing of mothers and their families (Beck, 2012). Although 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 addressed the issue of postpartum depression (U.S. Department of Health and Human Services, 2010).

Problem Statement

Discovery of postpartum depression is often delayed, and treatment is often inadequate or not initiated (Miller et al., 2016). Left untreated, severe consequences can occur. The most severe of these consequences are maternal suicide and infanticide. Early identification and treatment can prevent these adverse outcomes; however, assessment for postpartum depression is often inadequate, leading to missed opportunities to initiate early and appropriate management (Beck, 2016). The scientific literature was deficient in documentation of Imo State women's experience of the assessment and treatment process for postpartum depression. The purpose of this research was to provide an in-depth understanding of Imo State women's assessment and treatment experiences for postpartum depression. Such understanding may help postpartum mothers understand postpartum depression and seek help from health care providers to ensure timely assessment and management of their postpartum depression, thereby preventing or decreasing adverse outcomes.

Research Purpose

The intent of this qualitative investigation was to establish the extent to which Imo State postpartum mothers perceived that their emotional needs were met during their early postnatal visit and after and to describe their experiences of the assessment

measures and therapeutic management of their postpartum depression. The findings from this study provide information on Imo women with postpartum depressed felt that they were sufficiently assessed and treated for postpartum depression. According to Ekwerike (2015), the prevalence of postpartum depression among Igbo ethnic group of Eastern Nigeria is 30.6%. Few scholars have examined the postpartum experiences of racial/ethnic women (Ekwerike, 2015). Moreover, few researchers have explored Imo mothers' beliefs and perceptions, symptom experiences, and postpartum risk assessment. There was a need to further explore postpartum depression assessment among Imo mothers. Determinations of how Imo women perceive the assessment and care they received for their postpartum depression will help health care practitioners design applicable assessments and care for women with postpartum depression.

Research Questions

RQ 1: How do Imo State mothers perceive assessment of mental health during pregnancy?

RQ 2: What is the lived experience of the assessment and treatment procedure for Imo State mothers with postpartum depression?

RQ 3: To what extent do Imo State mothers perceive their emotional needs have been met during postnatal visits?

RQ 4: What are common attitudes regarding assessment of stressful events experienced by Imo State postpartum mothers?

Conceptual Framework

Women experiencing postpartum depression often express a feeling of hopelessness, powerlessness, and lack of control (Peterson, 2014). 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. 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.

Empowerment theory was used in this investigation to understand the study participants' experiences of postpartum depression. Peterson (2014) noted that empowerment theory has its origin in the work of Freire. Women experiencing postpartum depression have identified feelings of hopelessness, powerlessness, and lack of control as issues that are characteristics of their illness (Peterson, 2014). Empowerment is a process, and the goal is to allow individuals to achieve the independence and confidence that will help them recognize and meet their own health needs (Chambers & Thompson, 2009). Empowerment theorists focus on returning power and control to those experiencing powerlessness. Although many researchers have focused on empowerment as an outcome, Hur (2006) examined empowerment as a process. Hur described the process of empowerment in different arenas. In the field of health studies, empowerment involves "uncovering experience, knowledge development,

promoting competency, and using self-assurance to make their voices heard" (Hur, 2006, p. 527). The reality of powerlessness and alienation is the first step in the empowerment practice. Another step in the practice is realization or awareness that there is lack of power and the possibility to gain power and change a person'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.

Nature of Study

To answer the research questions, a phenomenological study was conducted. Data collection methodology to investigate the research questions included individual, face-to-face interviews with mothers who had a clinical diagnosis of postpartum depression and received treatment.

Definitions

Competence: Another concept of personal empowerment, competency involves a person's acceptance that he or she has the skills required to competently fulfill his or her responsibilities.

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.

Impact: Impact is a construct of personal empowerment in which an individual feels a sense of command over organizational outcomes (Hur, 2006).

Meaning: Meaning is a construct of personal empowerment that involves a balance between a person's values, beliefs, behaviors, and roles.

Postpartum depression: Postpartum depression is a depressive illness characterized by two or more depressive symptoms lasting more than 14 days postdelivery (Corwin & Arbour, 2007). There are three well-known postpartum psychiatric mood disorders generally termed postpartum depression: baby blues, postpartum 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. Women experiencing the baby blues were excluded from the study.

Postpartum depression or postpartum nonpsychotic depression: Postpartum psychosis that typically continues for more than 14 days postdelivery, and resolution typically requires some intervention.

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 a construct of personal empowerment in which a person experiences a good judgment of personal control over responsibilities.

Treatment: Treatment is defined as pharmacological and or nonpharmacological interventions employed in the management of postpartum depression.

Assumptions

It was assumed that the participants were willing to share their experiences and provide open, honest answers to questions. Additional, it was expected that the study participants would have views on the assessment and management of their postpartum depression that they would disclose. Nevertheless, I predicted that that the study participants may feel the questions and recording of answers as interfering and be unwilling to completely reveal their true feelings and opinions about their experiences. The usefulness of the information provided would have been inadequate if the participants refused to answer questions truthfully. It was also anticipated that the participants would be honest when answering interview questions, and the information received by the participants could be generalized to represent the Imo State mothers.

Scope and Delimitations

In this study, I focused on the lived experiences of women with postpartum depression. Ten women from Imo State, Nigeria were recruited and interviewed. The women were recruited through the sharing of a flyer at the Emekuku General Hospital, Imo State, Nigeria. This study was limited to women 18 years or older who had experienced postpartum depression. Those experiencing postpartum blues or postpartum psychosis were not included. Additionally, participation was limited to women who were able to read and speak English, mothers of one or more children who were 6- months-old and above, and have received treatment for postpartum depression. Although the study findings may increase knowledge on postpartum depression, the findings were limited to

Imo State women and cannot be generalized to all women who experience postpartum depression.

Limitations

One of the limits to this study was the difficulty of recruiting participants who were willing to share their experiences of postpartum depression. It was assumed that individuals experiencing mental disorders are concerned about being labeled as "fanatical," which may lead to a problem in recruiting volunteers for the study. Horowitz and Cousins (2006) observed the impact that fear of stigmatization can have in decreasing treatment rates; some women may fail to discuss their feelings or fail to seek treatment. The participants may not want their interviews recorded in spite the guarantees of confidentiality and privacy. The second limitation to the study was that the findings could not be generalized to all women experiencing postpartum depression. This study provided some understanding into Imo –State women's experience of postpartum depression. It is important for health care practitioners to assess each woman and provide an individualized care based on each woman's individual needs and desires (Henderson & Redshaw, 3013). Also, this study was a phenomenological examination and did not provide quantitative reports of postpartum depression. The study findings were limited to analysis of identified themes.

The possibility of introducing response and interviewer bias into the study was considered a possible limitation. Response bias may occur when questions are constructed in a way in which participants choose a particular answer or answer in a

particular way based on the researcher's desires. Response bias may also occur if the presence of the interviewer affects the respondents' answers (Babbie, 2014). The interviewer 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 that the questions were structured to minimize these biases. 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, scholars can examine the questions to see if there is any likelihood of bias in the way the questions are phrased. 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 of the Study

Miller et al. (2016) viewed depression as the most onerous of all mental health illnesses. Miller et al. contended that postpartum depression affects at least 11% of women worldwide, and it a considerable category of depression. For many mothers experiencing postpartum depression, the complaint is long and incapacitating. Norhayati, Hazlina, Arsenee, and Emilin (2015) stated that postpartum depression is the most common mental disorder experienced by women postpartum and is a negative outcome for women in every culture. Many mothers who suffer from postpartum depression or postpartum psychosis have thoughts of hurting themselves or their infant, and the rates of suicide and infanticide among these women are high (Miller et al., 2016). Few scholars

have examined the postpartum experiences of racial/ethnic women (Ekwerike, 2015). Moreover, fewer researchers have explored Imo State mother's beliefs and perceptions, symptom experience, and postpartum risk assessment. There was a need to further explore postpartum depression assessment among Imo State mothers.

The infant is dependent on the mother for its health and wellbeing; postpartum depression, therefore, presents a threat to the health and wellbeing of the infant (Norhayati et al., 2015). In cases of infanticide committed by mothers experiencing postpartum depression, Schiller, Meltzer-Brody, and Rubinow (2014) contended that 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 incarceration of the mother, whom Schiller et al. viewed as a victim because her mental illness caused her to murder her infant. The results of postpartum depression are not limited to suicide and infanticide. Kathree, Selohliwe, Bhana, and Petersen (2014) described postpartum depression as a public health problem and contended that it affects infant and adult developmental processes. Kathree et al. detected that, in children, the negative effect on the mother-infant bond can increase the risk of compromised mental and motor development, difficult temperament, poor self-regulation, low self-confidence, and behavior problems. Postpartum depression can negatively affect childhood development.

Despite the indication that early recognition and management can change the course and effects of postpartum depression, many cases have gone under recognized and

inadequately managed (Beck, 2012). I expected that the study results will provide information on Imo -State women's understanding of postpartum depression and how to seek for help and treatment, which will enhance health care practitioner knowledge. Health care practitioners can use this knowledge to pursue appropriate identification and meet these women's needs. Further, this study will help in identifying that postpartum depression is a public health problem. By heightening public awareness of the problem of postpartum depression, advancement may be made toward making prevention a greater focus of public health. Societal change is also needed in the legal system's handling of women whose postpartum mental illness causes them to murder their infants.

Significance to Practice

There are gaps in the literature that need to be addressed in future research for the development of evidence-based policy decisions and service provision. This will include research about the ways to prevent, identify, and treat postpartum depression. There is a need for longitudinal studies on favorable interventions on mothers, maternal-infant relationships, and child development. There is a demand for public and health care professional understanding of postpartum depression and the local resources available for the treatment of women suffering from it. Programs associated with prevention, early detection, treatments, and the effects of postpartum depression on the maternal-infant relationship and child development should be provided.

Significance to Social Change

This study may result in a greater understanding of Imo State women's perceptions of the assessment and treatment processes for postpartum depression, which will enhance Imo women's knowledge on postpartum depression. The findings will also enhance health care practitioners' knowledge to encourage women to seek to timely assistance adequately meet their needs. Further, this study will help in heightening public awareness of postpartum depression as a public health challenge. By enhancing public understanding of the issue of postpartum depression, progress may be made toward prevention. Societal change is also needed in the judicial system's handling of women whose postpartum psychosis causes them to kill their infants.

Summary and Transition

Postpartum depression is a complex disturbance that can impact the woman, her children, her family, and society. Traditionally, the birth of a child is a joyous experience for a mother. Postpartum depression deprives the mother of the joy of motherhood and leaves her functionally and emotionally impaired. Women experiencing postpartum depression have reported symptoms of insomnia, emotional liability, lack of appetite, and feelings of powerlessness and lack of control (Yang, Liu, Chen, & Pan, 2014). Many have thoughts of harming themselves and or their infants. Postpartum depression is often unrecognized and untreated. Left untreated, the woman's emotional state and her symptoms of postpartum depression may worsen, and the potential for severe consequences of suicide and infanticide are increased.

Early recognition and adequate treatment are important in battling postpartum depression. The goal of the study was to explore Imo State women's experiences of the assessment and treatment processes for postpartum depression. Based on the study findings, the question of whether or not women perceived that they were adequately assessed and treated for postpartum depression was addressed. The study findings may help Imo State women understand postpartum depression and seek help. The findings will also help health practitioners in planning appropriate assessment and care for women with postpartum depression to make sure that their individual needs are met. A review of the literature on postpartum depression is presented in Chapter 2.

Chapter 2: Literature Review

The joy of motherhood is often heard in discussions about pregnancy and childbirth. However, the joy of motherhood is for many expectant and new mothers a myth (Beck, 2012). Even normal fear may cause pregnancy and childbirth to be a difficult experience for some women. For many women, motherhood brings distress and little or no joy because they suffer from 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 people who are severely depressed may act on suicidal and homicidal ideations.

Many studies have been conducted to determine the causes of postpartum depression to determine the most effective assessment approaches and to understand its effect on the child and family (Wisner & Pinto-Foltz, 2006). Few scholars have explored the experiences of women with postpartum depression. Specifically, there is a scarcity of studies on the assessment and treatment processes from the viewpoint of those who experience postpartum depression. In this qualitative study, the perceived sufficiency of the assessment and treatment experiences of women experiencing postpartum depression was evaluated. The goal of this study was to add to the understanding of postpartum depression.

The search strategy for locating articles is described before discussing the findings of this literature review. 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 researchers have viewed postpartum depression. Additionally, an examination of the effect 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, Medscape, PsychInfo, and CINAHL were accessed in Walden University's library using search words such as *postpartum, postnatal, postpartum depression, prenatal mood disorders, postpartum psychosis*, *treatment,* and *screening*. A review of the references used in the articles found through the 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.

Conceptual Framework

Women experiencing postpartum depression often express a feeling of hopelessness, powerlessness, and lack of control (Peterson, 2014). Empowerment theory, which is focused on returning power and control to those experiencing powerlessness, may help in addressing postpartum depression. Peterson (2014) observed that there are numerous definitions of empowerment. Chambers and Thompson (2009) viewed empowerment as a process aimed at affording individuals the self-sufficiency and self-confidence to recognize and address personal health needs. Researchers have often

conceptualized empowerment as a multilevel (multi-dimensional) construct that includes distinct, structural, and community level of examination (Peterson, 2014). Perkins and Zimmerman (1995) further demonstrated that empowerment research centers on determining capabilities and examining environmental determinants of social problems rather than classifying risk factors and assigning blame. Chambers and Thompson acknowledged the difficulty that professionals have conceptualizing the term empowerment and that empowerment resulted from an effort against authoritarianism.

Chambers and Thompson (2009) investigated nurses' understanding of the term empowerment and their use of the concept when engaged in health promotion activities in the acute care environment. The participants were 20 registered nurses who worked in an acute care setting in the United Kingdom. Study data were collected using six vignettes. Nurses were asked to present their plan for a health promotion process to meet needs of the subjects in the vignettes. Chambers and Thompson 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.

Hur (2006) described the method of empowerment in different disciplines. In the field of health studies, empowerment involves finding truth, knowledge development, promoting competency, and use of ability to make voices heard. Further, Hur showed that disaffection, understanding, involvement, and a sense of population were interconnected steps leading to empowerment. The reality of powerlessness and disaffection is the first

step in the empowerment method. The second step method is the realization or awareness that there is a lack of power and the possibility to gain power and change an individual'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. To overcome social oppression and achieve social justice, maximized human empowerment can be performed at the final stage (Hur, 2006).

Hur (2006) showed two interrelated categories of empowerment: personal or individual empowerment and collective empowerment. Personal empowerment is developed when individuals seek to develop the abilities to overpower their emotional and knowledgeable difficulties and reach autonomy, independence, and the ability to make decision (Hur, 2006). Collective empowerment occurs as a result of people joining forces to overcome barriers or obstacles to social change. Personal empowerment and collective empowerment both have their own set of four elements. The components of personal empowerment include significance, capability, autonomy, and influence. 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 suitable among the desires of one's effort responsibility and one's principles, belief, and behaviors (Hur, 2006). Competency is the opinion that a person has the ability and capacity required to ably perform his or her responsibilities.

Self-Determination

Self-determination refers to a person's sense of personal control over his or her work. Impact, on the other hand, is the person's perception of power on structural result (Hur, 2006). The elements of collective empowerment include shared belonging, community participation, and power over community group and structure. Collective belonging refers to being a part of a communal system of peers (Hur, 2006). Involvement in the community means active engagement in community affairs aimed at affecting change or redistributing power within the community. Power over group 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 aptitude to work together, problem solve, and make collective decision for social change.

Hur (2006) declared that there is an 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. Peterson (2014) discussed three dimensions of empowerment: resources, agency, and achievements. Resources are the conditions under which an individual makes choices, agency is the method by which a choice is made, and successes are the results 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 in their recovery. Researchers have recommended that

assistance with childcare be included in the treatment process. Yang et al. (2014) cautioned that, although 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 powerless and exhausted, empowerment could motivate her to stress, which could lead to hopeless and suicidal behavior. 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.

The empowerment process fosters self-esteem and autonomy and enables individuals to identify and address their own health needs. As Perkins and Zimmerman (1995) noted, empowerment-based interventions improve 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 Problems

Beck (2012) described postpartum depression as a crippling temper disorder, which can impact the mother-infant dyad. Beck observed that postpartum depression presents a potentially significant danger to the health and welfare of the infant due to the infant's dependence on his or her mother for his or her health and wellbeing. Postpartum depression refers to three conditions: postpartum or baby blues, postpartum depression,

and postpartum psychosis (Goodman, 2008). However, researchers have placed postpartum depression on a continuum of postpartum mood disorders that range from the baby blues to postpartum psychosis. Where an individual falls on the continuum is dependent on the number and kind of risk factors that the individual possesses. Beck (2012) pointed out that postpartum mood disorders have their own distinctive symptoms and that it is important to distinguish between postpartum depression and other postpartum mood disorders.

Postpartum Blues

Postpartum blues a common temporary disturbance in an attitude that occurs in some 30% to 75% of new mothers (Suri & Altshuler, 2009). Symptoms generally resolve within a few hours to a few days (American College of Obstetricians and Gynecologist, 2010). Many women who experience postpartum blues demonstrate emotional liability. Other manifestations of postpartum blues include sleep disturbance, anxiety, fatigue, absent-mindedness, irritability, lack of concentration, individual feelings of confusion, and headache. Suri and Altshuler (2009) observed that some researchers disagree as to whether a depressed mood is characteristic of the blues; however, other found a depressed mood to be a feature of the blues. Suri and Altshuler (2009) found that tears related to the blues are not related to sadness but rather to happiness. The baby blues have no clear diagnostic criteria and or identified etiology. Circulating hormone levels and psychosocial factors have been the focus of much of the research into the cause of the baby blues; but, the cause of the baby blues remains elusive. Postpartum baby blues

needs no treatment other than support and education. Some 20% of women who experience the baby blues will progress to postpartum depression; therefore, reassurance and support is needed (Suri & Altshuler, 2009).

Postpartum Depression

Suri and Altshuler (2009) defined postpartum depression as a nonpsychotic depressing occurrence that may begin or extend into the postnatal time. The most common psychiatric mood illness is postpartum depression. Postpartum depression reportedly happens in 10% to 22% of new mothers and generally occurs within 4 weeks post delivery Symptoms of postpartum depression may include lack of interest or desire in normal activities, weight loss or a gain in weight, no appetite, low self-confidence, insomnia or hypersomnia, significant fatigue or energy loss, beliefs of insignificance or hopelessness, feelings of guiltiness, a lessened power to focus, and frequent thoughts of suicide or thoughts of harming the infant (Suri & Altshuler, 2009). Having five or more of the previously identified symptoms, lasting 2 or more weeks, is diagnostic of postpartum depression. Suri and Altshuler pointed out that several of the signs of postpartum depression overlay with usual feelings experienced during the postpartum period. These normal experiences include sleep disorder, fatigue, and changes in weight. Because of this overlap, Seyfried and Marcus (2003) observed that some depression scales may have an increased rate of untrue positives. The Edinburgh Postnatal Depression Scale (EPDS) scale was found be fairly accurate, easy to administer, and has been validated in several studies (Wisner, 2013).The etiology of postpartum depression,

like that of the baby blues, is unclear. Biological and psychosocial factors have also been considered in an effort to understand the etiology of postpartum depression.

Suri and Altshuler (2009) suggested that there are some postpartum mothers with depression as a result of thyroid dysfunction; a link to changes in the circulation level of other hormones has not been found. There has also been no consensus among researchers on a link to psychosocial factors. Some women with a prior history of psychiatric depressive disorders are at an increased risk of postpartum depression (author, year). 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 (Suri & Altshuler, 2009). Women who experience postpartum depression are predisposed to later episodes of depression. Treatment for postpartum depression is generally the same as for a major depressive episode not related to parturition (author, year). Treatment is primarily pharmacological; however, sometimes no pharmacologic treatment is available to women who may prefer to have no medication.

Postpartum Psychosis

Suri and Altshuler (2009) discussed postpartum psychosis, stating that it occurs in one to two new mothers per 1,000 births. Suri and Altshuler noted that the onset of postpartum psychosis typically occurs within the first 2 weeks post delivery. Symptoms include elation, mood change, distractibility, increased activity, delusions, hallucinations, and an inability to function. Other symptoms of depression include feelings of guilt and

worthlessness, cognitive disorganization, bizarre behavior, and suicidal and homicidal ideations. Some scholars have indicated that there is a relationship between postpartum psychosis and bipolar disorder (author, year). Women suffering from bipolar disorder with a family history of postpartum psychosis are at a greater risk for experiencing postpartum psychosis themselves (author, year). Further, Suri and Altshuler pointed to an association between biological factors and postpartum psychosis. Suri and Altshuler noted that there is no significant association between biological factors and postpartum psychosis. However, there is an association between postpartum thyroiditis and postpartum psychosis (Suri & Altshuler, 2009). Additionally, primiparous women have been discovered to be more at chance of developing postpartum depression . The impact of postpartum psychosis can be serious for mother and infant; suicide and infanticide, although rare, can result (Bener, Gerber & Sheikh, 2012). Mood stabilizer and antipsychotic medications are often required to treat postpartum psychosis.

Effects of Postpartum Mood Disorder

The burden of postpartum depression has significant implications for the mother and her partner and infant. The negative impact on fathers and infants often compromises the mothers' mothering abilities (Wisner, Chamber, & Sit, 2006).

Mothers and Postpartum Depression

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 (Wisner, Chamber, & Sit, 2006). For those who are socioeconomically disadvantaged, Spinelli (2010) pointed out that the transition can be especially challenging. These women are at an increased risk for postpartum depression, nutritional deficiencies, and other adverse health outcomes. Further, they are more likely to lack social support and to experience violence at the hands of intimate partners (Spinelli, 2010).

Experiences of the Socioeconomically Disadvantaged:

Spinelli (2010) used a descriptive qualitative method approach to examine 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 (Norhayati et al., 2015). The second was an ongoing struggle to adjust to changes resulting from becoming a mother.

Expectations versus Reality of Motherhood

In a meta-synthesis of qualitative studies, Epifanio et al. (2015) found indications that women experiencing postpartum depression perceived a significant difference between the expectation and reality of motherhood. They observed that mothers described having feelings of overwhelming loss and downward spiraling. This, they observed, has led some researchers to conceptualize motherhood as being characterized

by a sense of loss. In their study, Epifanio et al. (2015) used grounded theory to investigate the occurrences of postpartum depressive symptoms in Swedish women. Women in the study reported feelings of dissociation from their work and a loss of their identity as competent professionals. Many of the mothers felt that they had lost their physical and emotional selves. The researchers found that the central theme among the study participants was a sense of struggle with everyday life. The mothers reported experiencing overwhelming moods of disappointment, guilt, failure, anxiety, loneliness, doubt, and grief.

The mothers also reported having difficulty relating to themselves, their infants, and their partners. The mothers had definite moral views and expectations of a "good mother," and they felt guilty for being unable to meet these expectations. The researchers noted that these mothers also struggled with childcare. They felt unprepared and uncertain in 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 interaction with other adults. These mothers also had difficulty expressing their feelings to relatives and friends for fear of having their feelings of being bad mothers validated or of being told that they had no valid reason for their dissatisfaction. The authors noted that "the mothers' unnatural feeling of being mothers assigned their feelings of depression to persona; weakness rather than to

sickness and feels guilty and disappointment, that created unwilling to talk about their feelings (Epifanio et al., 2015).

Communication with Infant and Partner

Adjustment to the new role of being a mother causes fatigue in some mothers and leaves them feeling guilty for not having enough energy to care for and interact with their infants for longer periods of time. Epifanio et al. (2015) noted that motherhood could also result in marital discord as partners have less time for each other and communicate with each other less often. Some mothers reported increased misunderstandings with their partners and that they often felt that the fathers were not helpful or supportive. Others reportedly encouraged paternal involvement in the care of their infants and felt that the fathers were supportive. Despite this, however, most felt that there were negative changes in their relationships to their infants' fathers.

Women's Perspectives versus Biomedical Perspectives

Corwin and Arbour (2007) observed that in the United States postpartum depression is an experience that is not well recognized. The biomedical perspective on the disorder may differ from the perspective of those experiencing postpartum depression. To better understand women's perspectives of postpartum depression and to help in reconciling the difference between these two perspectives, Corwin and Arbour interviewed women who self-identified as experiencing postpartum depression. Generally, the women believed that 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 cause of their developing 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 mothering ability, 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 feature of postpartum depression is the potential for suicide or infanticide. In the United States, recent incidents have heightened public awareness of postpartum depression and its potential devastating outcomes. Spineli (2010) pointed out that it is not unusual for mothers experiencing postpartum psychosis to attempt suicide or self-harm. Citing a dearth of information on suicidality during the prenatal and immediate postnatal periods, Spineli (2010) conducted literature review to determine suicide prevalence rates for prenatal and the postnatal mothers. The examination included both published and unpublished work. The authors conceptualized suicidality to involve intentional self-harm, suicide deaths, intentional suicide attempts, and thoughts of death and self-harm. The authors noted that a previous suicide attempt could result in a significantly increased risk of suicide death. The review indicated a lower suicide rate and suicide attempts among mothers who had practiced intentional self-harm than mothers in the general population. However, mothers who engaged in

intentional self-harm behaviors tended to use more deadly suicide methods. The authors concluded that pregnant and postpartum women's selection of more violent suicide methods was indicative of a greater level of intent.

Fathers and Postpartum Depression

Adjustment to fatherhood

Pregnancy and childbirth requires a great deal of adjustment on the part of the mother. Goodman (2008) observed that fathers are also required to make similar adjustments. Goodman 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, related to the ability to feel or palpate fetal movements. Depression or a dysfunctional partner relationship may inhibit paternal fetal attachment; encouraging the father's involvement in the pregnancy 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 unborn child. If there is a decline in sexual activity during the pregnancy, the father may find sharing even more difficult. The third task involves conceptualizing oneself as a father. Goodman (2008) observed that if the man is still needy or emotionally immature, he may have difficulty accomplishing this task because he will look to the child to help meet his own needs. The final task involves the determination of one's own

parenting style. Goodman (2008) argued that men often do not want to emulate their own fathers in their relationship with their own children.

Reaction to Mother's Depression

A father's response to his spouse's depression can significantly affect the outcome of such a depression. An initial supportive attitude may be replaced with a more dangerous or even vengeful attitude. Male partners may perceive symptoms of postnatal depression such as irritability and withdrawal from physical affection as rejection, which leads to anger, resentment, and maladaptive behaviors and is therefore likely to increase the woman's distress (Goodman, 2008). If the father and others must assume greater responsibility in caring for the infant, the mother may see this as proof of her maternal incompetence.

Paternal postpartum depression

Some men may experience postpartum depression (Paulson & Bazemore, 2011). Although Goodman (2008) argued that the phenomenon of paternal postpartum depression is questionable, there is evidence indicating that it does exist. Goodman (2008) conducted a study that examined the incidence, characteristics, and predictors of paternal postpartum depression. Goodman also investigated the association between paternal and maternal postpartum depression and the impact of parental depression on the family.

Goodman reviewed articles from 1980 to 2002 and found that paternal depression is not commonly discussed in the literature. Researchers collected data on paternal

postpartum depression at points ranging from 3 days to 12 months after birth. The measurement for paternal postpartum depression was the same as for maternal postpartum depression. The general occurrence of paternal postpartum depression varied in these studies 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 before the latter part 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 24 weeks postpartum.

Goodman identified numerous risk factors for paternal postpartum depression: personal history of depression, history of postnatal depression in a partner, and a dysfunctional relationship with the partner. The major predictor of paternal postpartum depression was maternal depression. Children are at risk when one parent is depressed, and when both parents experience 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.

Infant Care and Postpartum Depression

Infants are not immune to the impact of maternal depressive symptoms. Studies have demonstrated serious adverse effects for the infant in several areas when postpartum

depression is present (Paulson & Bazemore, 2011). 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 many supervision suggestions to parents of children in the first year of life. These recommendations are aimed at maintaining optimum health for infants, they include breastfeeding, making sure that infants sleep on their back, ensuring that infants do not sleep with a bottle, and having parents engage in positive interactive activities with their infants.

Postpartum depression is one factor preventing parents from following these anticipatory guidance recommendations. Paulson & Bazemore (2006) examined the effects of postpartum depression on compliance with anticipatory guidance. The researchers found moderate to severe depression in 14% of mothers and 10% of fathers in the study group. Mothers and fathers were least expected to follow 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 infants 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 non-depressed parent was less likely to engage in play activities with the infant.

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 mothers. Statistics, however, indicate that many infants experience less than nurturing mothering. Evidence suggests that postpartum depression can severely affect the mother-infant bond as well as the infant's social and cognitive development (Seyfried & Marcus, 2003). Stressors, including depression, can have a negative impact on mothering. Logsdon et al. (2006) conducted a study to "define the specific components of the maternal role and describe the effect 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 interactions with the mother help the infant to develop knowledge and skills and to become familiar with the external environment. If the interaction is optimal and the mother is successful in accomplishing caretaking tasks, the mother's confidence in her role will increase. However, the labor-intensive nature of caretaking may cause mother's stress level may also increase.

According to researchers, providing for the infant's health and development can also be stressful for the mother because 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 tend to find less.

Socio-Emotional Behavior

Researchers believe that infants as young as 3 months are aware of their mothers' depression because these mothers interact with their infants differently than do non-depressed mothers. Infants whose mothers are depressed have problems with social, cognitive, and emotional functioning (Field, 2010). These problems tend to persist into childhood. Depression for the children themselves is not uncommon. The researchers investigated "the relation between women self-reported operative and uninterrupted observations of maternal and infant socio-emotional actions in women 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 socio-emotional 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.

Field (2010) also evaluated the interaction of strangers with the infants. The researchers found that an unbiased stranger was more likely to have positive interactions with newborns of non-depressed mothers. Strangers were less likely to be as involved in their communications with newborns of depressed mothers. The researchers concluded

that infants of depressed mothers conveyed something others that compromised their communication with individuals other than their mothers. The researchers concluded that the baby's emotional reactivity might exacerbate negative interactions with the mother and further reinforce the mother's negative self-perception (Field, 2010).

Receiving Health Care

Minkovitz et al. (2005) evaluated the association between the frequency with which children received health care services and maternal depressive symptoms. 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 would be associated with less preventive care and more acute care. Mothers who reported depressive symptoms were more likely to be young, nonwhite, Hispanic, unmarried, and with less than a high school education. The researchers found that, children aged 2 to 4 month old received fewer preventive services and were more likely to have emergency department visits if their mothers had depressive symptoms. There was no association found between 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 telephone interviews 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.

Signs and Symptoms of Postpartum Depression

According to previous research, mothers suffering from postpartum depression show visible warning signs such as anxiety, insomnia, and confusion. They do not always appear depressed. Other obvious symptoms include uncontrollable crying spells and fear (Fitelson et al., 2010). Early detection of the symptoms is difficult since parents also learn to mask symptoms. The other symptoms include guilt, inadequacy, changes in appetite, and fatigue.

Postpartum depression persists when either mothers or physicians fail to recognize symptoms. The need to screen for postpartum depression is most pronounced mostly among racial and ethnic minority women because such populations tend to ignore depressive disorders. Insufficient assessment during medical encounters can also result in underdiagnosis of this condition. Despite the fact that postpartum depression is easily treatable, less than 40 percent of depressed mothers seek help, and only about 13 percent of women with signs of postpartum depression are under the care of a physician. Women who seek professional help have a recovery rate of about 80 and 90 percent.

Assessment

There is a well-recognized potential for significant negative consequences if postpartum depression is not identified and treated in a timely manner is well recognized (Beck, 2006). To make possible early recognition 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 College of Obstetricians and Gynecologist in its delineation of the pediatrician's scope of practice has included the assessment and consideration of parental and environmental factors that may affect children's health.

Norhayati et al. (2015) argued that in both clinical practice and various studies, the definition of postpartum depression is too narrow. The authors noted that the burden of the disease; the availability of an inexpensive, safe, simple, valid, and reliable diagnostic tool; and the existence of effective treatment options are considerations in determining whether or not postpartum depression should be routinely screened for. The likely impact of postpartum depression should also be considered in determining the need for routine screening. Maternal depression affects child development and the use of pediatric health care services. To aid in developing guidelines for screening, Chaudron et al. (2006) investigated the natural course of postpartum depression in 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 in the sample developed a high level of depression after the first 3 months postpartum. Based

on this finding, Chaudron et al. (2006) 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. These 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.

The researchers found that although the women were reportedly being treated during the study, 25 % 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. However, these screening tools are not without controversy. Paulden et al. (2011) conducted a methodical review of different assessment tools and created a model to determine their economic costs and associated health outcomes. The researchers used a hypothetical population of women as their study participants. Of the assessment 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 assessments added to the cost of healthcare.

Therefore, they concluded that formal identification methods did not appear to represent a good value for the money spent. Paulden et al (2011) evaluated the rates of diagnosis and treatment for postpartum depression before and after implementing routine screening with EPDS. Three hundred and forty-two women who received care in a community postnatal care clinic were involved in the study. Half the mothers (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, only 68 were diagnosed as clinically depressed upon follow-up evaluation by a clinician. The study showed a more than twofold increase in clinical diagnosis of postpartum depression with routine EPDS assessment when compared to the rate of diagnosis without the tool. The researchers concluded that routine EPDS use might be associated with increased diagnosis and treatment.

Gjerdingen and Yawn (2009) conducted a literature review focused on recognizing postpartum depression through depression screening. They examined current assessment practices and methodologies and barriers to postpartum depression assessment and treatment. The authors observed that there is little published literature on patient outcomes with assessment for postpartum depression. The literature review demonstrated the importance of assessment. The authors cited several studies that pointed to the widespread impact of postpartum depression. The authors examined a number of screening tools and concluded that further studies with large representative samples are

required to help recognize the best postpartum depression assessment tool, one 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' first pediatric clinic visit as opportune times for postpartum depression assessments. Well childcare visits, they argued, provide a convenient longitudinal opportunity for screenings at regular periods throughout the first year after birth. Further, 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 assessment 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 assessment 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 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 assessment. These factors are occasional follow-up visits for mothers, absence of objective, proactive monitoring of recovery, and separation

of primary care and mental health services. The authors echoed the recommendation of conducting routine depression assessment 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 assessment tool.

Treatment Plan

Postpartum mood disorders are often underdiagnosed and inadequately treated. According to Suri and Altshuler (2009), 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, non-pharmacological, or both. Researchers have evaluated various aspects of the treatment process and modality for postpartum depression.

Beck (2012) 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. Feminist writers oppose the medical model and assert that the medicalization of childbirth is a likely contributor to the risk of postpartum depression. Proposed interventions based on feminist theory involved giving voice to the mother, validating her experiences, and reinforcing her sense of personal power. From the perspective of attachment theory, postpartum depression is believed to result from a dysfunctional relationship between the mother and her partner (Beck, 2012). 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. If the husband or partner fails to participate in the therapeutic intervention, individual therapy or interpersonal therapy is employed. Interpersonal theory is another theoretical framework on which postpartum depression treatment is based. This perspective views humans as social beings whose interpersonal interactions impact their personalities. If these interpersonal interactions are negative, they can be anxiety producing and can result in postpartum depression. Interventions based on this theoretical perspective are focused on interpersonal relationships and are collaborative efforts between the mother and therapist (Beck, 2012).

Postpartum depression, viewed from the self-labeling theoretical perspective, is seen as a violation of social norms and expectations surrounding childbirth. The mother has discordant feelings towards childbirth and motherhood resulting in a depressive state (Beck, 2012). 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. Because the mother recognizes her mental distress, she voluntarily seeks help for her disorder. Interventions based on this theoretical perspective involve psychotherapy and/or self-help groups.

Beck (2012) 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. 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 knowledgeable of the dangers 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 the twelve study subjects who were breastfeeding, a majority (62.7%) chose interpersonal psychotherapy alone. Most of the women (80.7%) with past 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 levels of depression. Based on this finding, the researchers concluded that all three treatment approaches were effective in treating postpartum depression. Forman et al. (2007) 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 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 1/2 months, assessments of early management of infant behavior, early problems in the mother-infant bond, and mother-infant interaction were conducted.

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 reductions 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 behavior and emotional problems, infant attachment, and cognitive development. Later infant behavior and emotional problems were less in 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. Forman et al. (2007) 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 with postpartum depression symptoms at 2 to 4 weeks post-

delivery. Of the 1,215 women from a community-based population who were screened, 122 women were identified as having symptoms of postpartum depression and 117 of the 122 completed the study. Horowitz (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 Options

Healthcare providers are encouraged to involve patients, including those with mental illness, in decisions about their care so that their perceived needs may be addressed. Terry (2007) noted that over the last three decades there has been a change in the clinician-patient relationship from paternalism to an equal partnership. 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 (2008) observed that because the discipline of public health is not focused on the health of individuals, 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 diseases, not infectious ones. 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 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.

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 suggested that some federal research, geared at weak behavioral interventions, is based on the view that harmful behaviors result from "senseless and pathological factors," (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 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 (2011) argued that of the different types of clinician-patient interactions, only those in which the clinician and the patient contribute or co-provide care are helpful. In co-provision, clinicians provide clinical expertise and patients provide expertise on their bodies, life situations, principles, opinions, and preferences (Buetow, 2011). Buetow pointed out that clinicians and patients enable each other therefore each has the authority to "elucidate role doubts, discuss difference of interest, and act in their own capacity" (p. 554). Co-provision as a model of care allows for mutual participation but does not demand equality. Buetow noted that equality is not always desired and may not always 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. Consumerism also hinders care, and minimizes and devalues the role of the clinician.

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. Deegan and Drake examined the shared decision-making process from the perspectives of the client and the practitioner. In particular, they focused on shared decision making for medication management for individuals

recovering from mental illness. Shared decision-making recognizes skill of the client and the practitioner and requires that they agree on treatment goals and the path to accomplishing such goals. They argued that medical paternalism fails to admit the important position 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. 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 for the 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. The view that patients and their values should be respected if good medical care is to be attained is at the core of this partnership. However, Terry pointed out that a physician might 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 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) so that the patient will view the physician's 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. As Terry pointed out, patients do not always want to make a decision by themselves and should be asked how and with whom 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

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. According to Richards (2009), 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 firm, rigorous, trustworthy, and systematic. The response from supporters of qualitative research was that their data were sensitive, nuanced, detailed, and contextual. Trochim and Donnelly (2007) viewed this dispute as counterproductive. Richards (2009) pointed out that quantitative data and qualitative data are interconnected. Further, Richards argued, all quantitative statistics is based upon qualitative results and all qualitative information can be explained and influenced statistically. Babbie (2014) observed that there is widespread recognition of the contribution of both approaches.

Quantitative research is described as a recognized, objective, methodical process to explain and measure associations, and to investigate causal relationships among

variables. Quantitative data and quantitative variables are expressed numerically and quantitative data are said to be confirmatory and deductive in nature. Babbie (2014) observed that a quantitative approach allows for ease in aggregating, comparing, and summarizing the data. However, quantitative approaches risk losing some richness in the meaning of the data.

Qualitative research is a methodical, interactive, subjective process that describes phenomena and explores the meaning of life experiences. Qualitative data and qualitative variables are not expressed numerically, but rather in text, pictorial, audio, or other forms. Richards (2009) described the nature of qualitative data as exploratory and inductive. According to Richards (2009), 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 contexts in which health choices are made.

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); its etiology and duration (Chaudron, et al., 2006); rates of identification and treatment; and efficacy of various treatment modalities. Qualitative researchers have explored women's explanations of postpartum depression their explanation of the reality

of the postpartum period, their experience with seeking care (Sword, Busser, Ganann, McMillan, & Swinton, 2008), as well as other issues.

Some researchers, such as Creswell (2013), have used mixed methods to further understand postpartum depression. No study that explored women's lived experiences of the assessment and treatment process was found in the literature. I conducted this study to describe women's experiences of the assessment and treatment process for postpartum depression and to determine their view of that assessment and treatment process. The focus of the study is the subjective experience of women with postpartum depression. Thus, I chose the phenomenological approach, which centers on the subjective experiences of individuals, for this study. Sword et al. (2008) described several qualitative approaches. These include ethnography, field research, grounded theory, case study, and phenomenology.

The ethnographic approach is employed when a whole culture is the focus of the study. 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 (Sword et al., 2008). The literature has not identified a natural state or environment for postpartum depression and it is not my goal to investigate postpartum depression in any particular state or environment, so the field research approach was not effective for this study. The grounded theory approach is used to develop theory about the phenomenon being investigated (Sword et al., 2008), which was not a goal of this

study. Creswell, (2013) defined a case study as an in-depth investigation of a particular individual or perspective. Babbie (2014) noted, "the limitation to a particular instance of something is the essential characteristic of the case study. The case study approach could effectively illuminate the experience of an individual. However, this approach is not chosen because my concern for this study is not a particular individual or occurrence of a phenomenon.

Phenomenology focuses on individuals' subjective experiences and perspectives. Ashworth and Greasley (2009) 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. Ashworth and Greasley (2009) 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 will be sought. Interpretive phenomenology focuses on what humans experience rather than what they consciously know. Interpretive phenomenological studies can illuminate aspects of the experience of phenomena that may be beyond the level of consciousness. For this study, I chose the interpretive phenomenological approach because in this study, I seek to enlighten Imo women and practice through the focus on the subjective experiences and perspectives of women who have been assessed and treated for postpartum depression**.**

Summary

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 contribute to postpartum depression. In discussing the three conditions generally known as postpartum depression, Almond (2009) noted that the etiology continues to be a mystery. The literature review has shown that postpartum depression's impact on the mother, her partner, and her offspring can be severe. For mothers, postpartum depression makes motherhood and the adjustment to parenting very challenging. The mother's interactions with her partner and infant can also be severely affected. Fathers must also adjust to fatherhood. Their adjustment and their relationship to mother and infant can be negatively influenced by postpartum depression. For infants, postpartum depression can adversely affect parental compliance with anticipatory guidance recommendations (Paulson, et al., 2006), mothering, socio-emotional behavior (Weinberg & Tronick, 1998), and their overall health care.

Timely identification and treatment is essential for the effective management of postpartum depression. The American College of Obstetricians and Gynecologists and the American Academy of Pediatrics are among professional organizations that have developed guidelines for postpartum depression assessment. Several tools have also been developed to promote assessment. Researchers have evaluated the effectiveness of assessment tools and identified barriers to their successful application. Beck (2012)

identified several theoretical viewpoints of postpartum depression and associated treatment modalities, both pharmacological and non-pharmacological.

In discussing these viewpoints and related treatment approaches, Beck concluded that a treatment is not necessarily limited to a single perspective and that an approach combining two or more treatment modalities may be more effective. In deciding treatment, consideration must be given to both the various approaches to treatment but also to the mother's needs (Pearlstein et al., 2006), and the mother's involvement in the decision-making should be encouraged. Involving mothers in treatment decisions to address their postpartum depression fosters empowerment, which serves to enhance wellness, self-esteem, and autonomy (Chambers & Thompson, 2008). I used empowerment theory in developing the interview questions for understanding the participants' perception of the assessment and treatment processes for their postpartum depression. The literature review presented no information on patients' view of the assessment and treatment processes. In this study, I intended to fill this gap by employing an interpretative phenomenological approach to study the problem. I selected the interpretative phenomenological approach because my aim in this study was to enhance knowledge about Imo State women and inform practitioners. A description of the study methodology or approach as well as the researcher's role is presented in Chapter 3.

Chapter 3: Research Method

For some mothers, the birth of a child brings emotional turmoil and distress rather than joy and happiness. These women suffer from postpartum psychiatric mood disorders, commonly called postpartum depression. There are three well-known postpartum psychiatric mood disorders: baby blues, maternity blues, or postpartum blues, and they are experienced by some 50% to 85% of new mothers (Thomas, 2007). Postpartum depression occurs in 8% to 15% of new mothers (author, year). The third and most severe form is called postpartum psychosis, and it affects 1 to 2 women per 1,000 deliveries (author, year). Postpartum psychosis is a psychiatric sickness that requires emergency hospitalization and treatment.

Sword et al. (2008) 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 assessment and treatment process for women with postpartum depression and whether or not these women perceived their emotional needs were adequately met. Therefore, a phenomenological approach was chosen. Sword et al. described phenomenology as "a human science," that studies persons. The goal is to examine that which is unique to individuals rather than that which is generalizable. Data were gathered through in-depth interviews, and the data or text were examined for themes. According to Ashworth and Greasley (2009), phenomenology involves a process through which the researcher sets aside his or her prejudices and biases and pays attention to the text. Ashworth and Greasley called this the interpretative

circle and noted prejudgments are corrected in view of the text, the understanding of which leads to new prejudgments. Further, through reflective interpretation of the text, the researcher achieves a more meaningful description and interpretation of the experience being investigated.

Research Design and Rationale

I used the interpretative phenomenology research methodology to conduct this study. The aim was to understand the lived experiences of Imo State women with postpartum depression and whether or not they felt that their emotional needs were met. Four primary research questions were addressed.

1. How do Imo State mothers perceive mental health and assessment of mental health during pregnancy?
2. What is the lived experience of the assessment and treatment procedure for Imo State mothers with postpartum depression?
3. To what extent do Imo State mothers perceive their emotional needs have been met during post-natal visits?
4. And finally, what are common attitudes regarding assessment of stressful events experienced by Imo State postpartum mothers?

Phenomenological research typically through interviews an informal, interactive process and utilizing open-ended comments and questions (Ashworth & Greasley, 2009). The data were collected through individual, face-to-face, in-depth interviews. This permitted me to probe further into answers that the participants gave. Participants were

asked open-ended questions included main questions, probes, and follow-up questions. Sword et al. (2008) suggested formulating four to six main questions. Sword et al. pointed out that the researcher may or may not use all main questions and cautioned against inserting the researcher's own understanding or examples in presenting a main question 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 (2005) also warned against probing with every question in case the researcher loses sight of the main point, disrupts the course of the interview, or irritates the interviewees.

I invited follow-up questions if there was an indication that relevant information was missing or if I needed further depth and understanding of the main point. The questions were constructed using the empowerment theory to gather information on components of empowerment theory, as well as the participants' perceptions of the assessment and treatment processes for their postpartum depression. To enhance the sufficiency of the data collection, interviews were audiotaped, and handwritten notes were taken. Sword et al (2008) 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 the areas that required further probing or to emotions that indicated areas of sensitivity that required changing the line of questioning. I prepared mentally by acknowledging and reflecting on any biases and preconceived thoughts I had about postpartum depression and on what the participants may or may not disclose before each

interview. According to Sword et al., a person's common sense, preunderstandings, suppositions, assumptions, and the existing bodies of scientific knowledge predispose an individual to interpret the nature of the phenomenon before we have even come to grips with the significance of the phenomenological question.

Sword et al. (2008) stated that researchers must first make explicit their understandings, beliefs, biases, assumptions, presuppositions, and theories. In transcendental phenomenology, the researcher brackets or sets aside these biases and preconceived notions. Bracketing is a process of cleansing the consciousness in which the researcher reserves prejudgments, biases, and preconceived ideas about thing (Sword, 2008). However, in phenomenology, self-reflection allows researchers to be conscious of their biases and preconceived, but they are not bracketed to the same extent as required in transcendental phenomenology. They are given consideration and are included in the data interpretation. According to Sword et al., although 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. I maintained a detailed journal of my thoughts, feelings, and reactions during the interviews and analysis process. I included these journal entries in the interpretation of the data.

Researcher Role

In this study, my key responsibility was researcher was to be the human instrument. I aimed to identify issues relating to the study, determine why the study may

or may not work, identify the problems that may rise during the study, and suggest solutions or solve these issues that may affect the study. The qualitative researcher is the force that drives the progress of the research. The researcher must also avoid bias in data collection, which requires measures to identify the tools for the collection of data. The researcher must know that others will use his or her work; and therefore, the scholar must avoid bias. Babbie (2014) stated the researcher could demonstrate 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 in asking the questions, verbal language, or my body language.

Richards (2009) pointed out that bias could be useful in a carefully designed study by taking into account the factors that are already known. The researcher's bias should be addressed in the research design. The first step in addressing the researcher's bias, Richards suggested, is to acknowledge and openly state bias. I am a female, born and raised in Imo State, Nigeria, and I am a nurse whose profession primarily involved caring for medically ill patients. I have a younger sister who is married and has four children, who experienced postpartum depression with her third child. I believed that there was a lack of understanding of her condition on both the part of professionals and the public and that this lack of understanding led to her being marginalized, misdiagnosed, 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 postpartum depression as evidenced by literature that showed

that postpartum depression has continued to be underdiagnosed and insufficiently treated (Richard, 2009). I believe that women experiencing postpartum depression should be provided with proper treatment. Should failure in timely identification and insufficient 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 was aware of my views and values regarding the issue of postpartum depression. As Richards recommended, I acknowledged my views and values but did not interpret the study findings based on those views and values. Although self-reflection and open acknowledgement of the researcher's biases and preconceived thoughts and ideas must be acknowledged, the interpretative phenomenological approach does not require grouping as in transcendental phenomenology.

Methodology

The study participants were women who have had a clinical diagnosis of postpartum depression and who were treated or were receiving treatment. Because the onset of postpartum depression is usually a few days to 4 weeks post delivery (Miller et al., 2016) and the first postpartum visit is not until 6 weeks postpartum, postpartum depression may not be identified prior to the 6th postpartum week. In this study, my aim was to involve women who had been treated for postpartum depression; therefore, I interviewed mothers whose children were older than 4-months-old.

Participants were recruited using a purposeful sample of mothers from a postpartum depression center. The Ememkuku hospital Postpartum Center based in

Emekuku, Imo State, Nigeria has a postpartum depression center. I distributed flyers and recruited participants at this site for volunteers. I offered 15 dollars gift cards to participants as an incentive for volunteering. Potential participants responded to my invitation through my contact information included in the flyer and were individually contacted to discuss the study purpose, criteria for inclusion, confidentiality, informed consent, and their rights as participants (including the right to withdraw at any time). Questions or concerns that potential participants had regarding the study were answered. Researchers who allow the participants to ask questions not only provide clarity about the research, but also build rapport between the researcher and study participant (Richards, 2009). 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 provide the researcher more insights into the participants' perceptions. Women who expressed enthusiasm to participate in the study were asked to sign 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, although the reports of their experiences will be published, no naming would be included and confidentiality would be maintained. Additionally, I obtained the participants' permission to electronically record the interviews. Participants consisted of 10 mothers of one or more children; who were 6 months or more postpartum; and who had been assessed, treated, or received treatment for postpartum depression.

Richards (2009) did not recommend a sample size for qualitative studies and contended 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). A qualitative technique requires a substantial amount of time, and a large sample size is not necessary. Creswell (2013), however, recommended an upper limit of 10 participants for phenomenological studies. Participants were women 18-years-old, who could read and speak English, mothers of one or more children, 6 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 had 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 (Miller et al., 2016). Women experiencing postpartum psychosis were 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 (Miller et al., 2016). The women who were observed to have these signs and symptoms at the time of the study were excluded and referred to a mental health professional, as postpartum psychosis is a psychiatric attention. The study participants were women who had a clinical diagnosis of postpartum depression, the second of the three postpartum conditions, and who were receiving or received treatment. To determine whether or not

possible participants had a clinical diagnosis of postpartum depression, I asked participants how the diagnosis was made.

Data Analysis

Walden University provided institutional review board (IRB) approval for the study. Following IRB approval, data collection for the study began. Prior to conducting the actual study, a pilot study was conducted with four women. The data collection and analysis of the pilot test helped me to determine 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 changes were necessary. As soon as possible after each interview, I transcribed, verbatim, audio recordings and notes for each interview. The transcribed data were organized by participants, 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 the data to 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

has a high internal validity because the coding system is close to the text and the research question. I asked for clarification of ideas or statements as needed from the study participants. The inductive coding method was chosen for analysis over the deductive coding method because, as Kortendick and Fischer 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.

The inductive method is determined by the data, and code book development is not required. 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. To facilitate the data analysis, I examined the text to develop themes. The techniques that I used in identifying themes were listening or looking for interesting or unfamiliar terms used by the study participants and listening and looking for word repetitions. Further, I used constant comparison, which involved the analysis and comparison of each item with the remainder of the data (Pope et al., 2007). 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. Transcripts of 10 interviews were uploaded into NVivo 9 for coding, categorization, and analysis of emergent themes. To code the data, I

read the transcripts and classified descriptive statements stored at nodes. Nodes are areas where data segments can be coded and stored for further analysis. Attention was given to the likelihood that one or more cases would not follow the data trend or, as Creswell (2013) described it, will be of divergent perspectives. Freeman et al. (2007) suggested against insufficient analysis of these inconsistency cases. Data were analyzed systematically for inconsistency cases and to ascertain if such cases were distinct and to account for such special perspectives.

Issues of Trustworthiness

To ensure the trustworthiness of a qualitative study, it is important to demonstrate four elements: credibility, transferability, dependability, and conformability. Credibility relates to the researcher's confidence that the phenomena being explored are correctly recorded (Creswell, 2013) Approaches that can assist in establishing confidence include the appropriate selection of the research methodology, sampling method, and triangulation, as well as employing best practices to ensure that participants provide truthful answers. The selection of a recognized and proven research approach can foster credibility. The phenomenological approach, described earlier in this chapter, is a well-established approach, and it was selected as the best approach for this study. Creswell (2013) noted that the use of random sampling of research participants might refute accusations of researcher bias in qualitative studies. In this study, I used purposive sampling. Although this approach may not ensure the same distribution of what Loh,

(2013) referred to as unknown effects, the participants were from Imo State, Nigeria and thus there was an extensive range of informants.

Having a large number of informants is one method of triangulation, another strategy for enhancing credibility. In triangulation, data from one participant can be crosschecked with data from other participants. Creswell observed that, individual viewpoints and experiences can be confirmed against others, and eventually, a rich picture of the attitudes, needs, or behavior of those under scrutiny may be constructed based on the contributions and range of people. Similarly, comparing data from participants at different sites, referred to as site triangulation, may foster credibility. Only site was chosen for recruitment of participants. Credibility was assured by ensuring that participants provided honest responses (Creswell, 2013). Strategies included 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. I developed a relationship with each study participant by meeting each one, describing the study to them, defining my role and purpose, obtaining their consent to involve them in the study, and providing them with the opportunity to opt out at any time. Additionally, ethical guidelines were outlined more in this section, which created credibility and protected 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 beyond the initial study. Individual perception of the same or similar phenomenon may differ.

Creswell (2013) contended 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. Ashworth and Gtrasley (2009) 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 a study's methodology allows others to replicate the study. This is the hallmark of dependability, the third element of trustworthiness. Ashworth and Gtrasley (2009) emphasized the need for accurate reporting as a means of assisting others to not only replicate the study but also to evaluate the degree to which correct research techniques were employed. Ashworth and Grassley noted that the goal of repeating the study might 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's findings and may partially account for divergence in study findings.

Confirmability, the fourth element of trustworthiness, involves minimizing 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 (Ashworth & Grassley, 2009). Loh (2013) noted that this is an area in which triangulation can also be of value. The researcher's open acknowledgement of

biases is encouraged as a way of furthering confirmability. As with dependability, a detailed description of the study procedures can promote confirmability by outlining strategies used to minimize bias. In this chapter I provided a detailed description of the research plan and procedures, along with a disclosure of my role and biases and the actions I took to minimize those biases. In Chapter 4, I provide a more detailed description of the study participants, data analysis, and study findings. Further I outline the steps I took 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 published by the World Health Organization (2011). The IRB approval process ensures that researchers adhere to these ethical guidelines. For this study, I obtained IRB approval from Walden University. 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 important that steps be taken to address these concerns so that the research participants and all stakeholders will be assured that the research does not violate ethical standards. The safeguard of the dignity, wellbeing, and rights of research participants is recognized as an important responsibility for researchers today. Ethical research includes being truthful to participants about the purpose of the research,

maintaining confidentiality, protecting participants emotionally, and respecting the participants (Richards, 2009). The researcher can demonstrate respect to participants by not deceiving interviewees, by being honest about the researcher's identity and intent, and by not promising research benefits that the researcher cannot deliver are all ways. Respect also involves the manner in which the researcher interacts with participants (Richards, 2009).

This study involved women who experienced postpartum depression. As such, there may be questions regarding their mental state and concerns about 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. Taking part in the study was entirely voluntary and the study participants were informed of their right to withdraw at any time if they so desired. Richard (2009) recommended that, if an 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. Postpartum depression can cause severe emotional disturbances and reliving these emotions might have been difficult for the participants in this research. I made an effort to shield the participants from emotional distress and did not pursue questions to which participants showed or expressed discomfort. If a study participant had showed significant distress because of the study,

participant would have been referred to an appropriate healthcare service. None of the participants showed or expressed such distress.

Study participants were assured that their participation would remain confidential. Participants were given the opportunity to select which of the study conference rooms would be used for their interviews. This was done to give them additional control over the interview process. Privacy and confidentiality were maintained in the conference offices selected by the participants for interviews. Each interview lasted 30 to 60 minutes. No personally identifiable information was included in the data. The interview's written notes, electronic recordings, and computer files were stored were kept in a secured and locked location accessible only to me. Rubin and Rubin (2005) stated that researchers must evaluate the potential for harm in what is reported. In this study, the relevance of each disclosure as well as likely harm to participants that could result were evaluated. It was not anticipated that there will be any disclosure that will likely cause harm.

Summary

Current health care is moving from a paternalistic model of care to a model of shared decision making in which health care practitioners and clients set mutually determined goals (Taylor, 2005). In this study, I intended to determine whether or not postpartum Imo State women perceived that their emotional needs were met during their initial and follow-up postpartum visits. The results addressed the question of whether or not women with postpartum depression felt that they were sufficiently assessed and treated for their condition. Determinations of how women feel about the assessment and

care they receive for postpartum depression can help healthcare professionals to plan appropriate care for women with postpartum depression. By understanding patients' opinions on the healthcare they receive, providers can better address the needs of their clients. The results from this study can be used to plan for the appropriate assessment, referral, and care of women with postpartum depression. Results are offered in Chapter 4, and they include discussion of identified themes.

Chapter 4: Qualitative Data Analysis

Introduction

The results of this study are outlined in Chapter 4. In this study, I investigated women's perceptions of the assessment and treatment procedures for postpartum depression. Comprehensive interviews were conducted with 10 women who experienced postpartum depression. The plan for this study comprised recruitment of participants, data collection and storing, data analysis, developing themes, and summary. NVivo 9 was used to enable the data analysis. NVivo 9 was used in the storing, organizing, categorization, retrieving, and searching the data to assist in classifying themes. Recruitment of study participants was conducted at the Emekuku Hospital Imo State, Nigeria.

Pilot Study

Following IRB approval, the initial data collection and analysis for this study began with the enrollment of the first four 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, criteria for inclusion, confidentiality, informed consent, and their rights as participants, including the right to withdraw at any time. I evaluated the answers that the four pilot participants offered to the interview questions during and after the interview to ascertain if changes to the

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

Participants Demographics

Women who suffered from postpartum depression were recruited to participant in this study with the assistance of a flyer. The flyer, comprised of a brief explanation of the study and my contact information, was distributed at the Emekuku hospital information tables and boards. I also distributed flyers by hand at the Emekuku postpartum clinics. Thirty participants telephoned me and were assessed for inclusion in the study. I met with each prospective 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. Fifteen of the 30 women were excluded; of these, two withdrew after hearing the explanation of the study, and three were excluded as they reported experiencing postpartum blues and not postpartum depression. Ten participants were involved in the study. The first four participants enlisted for the study were used in the pilot study and included in the study as the enlistment procedures, criteria, and selection method were the same for these participants as the other participants.

The ages of the participants were 18 to 45 and all Imo State women. The participants were asked to pick a name to use during the interviews. These chosen names were Nkechi, Ego, Ada, Olanma, Udoka, Uche, Nneoma, Ngozi, Munachi, and Eziaku. Nkechi was a kindergarten teacher who was married with two children. She was receiving pharmacotherapy for her postpartum depression. Uche, Nneoma, Ngozi,

Munachi, and Eziaku were business women. Ego had four children and had just lost her husband at the time of data collection. She received pharmacotherapy for her postpartum depression. Ada had one child and was living with her husband, but was not happy in her marriage. She sought advising for her postpartum depression. She had had six miscarriages and believed that her husband pressured her to become pregnant, accused her for the failed pregnancies, and was unsupportive. Olanma had six children and had support from her spouse. She stated that she experienced postpartum depression following the birth of her fifth child. She received pharmacotherapy and group therapy for her postpartum depression and was still in therapy during the time data collection. Udoka was a widow with three children and received pharmacotherapy for her postpartum depression. Uche was a mother of five with a 7-year gap between her fourth and fifth pregnancies. She stated that she received both psychotherapy and pharmacotherapy for her postpartum depression. Like Udoka, Uche reported experiencing postpartum depression following the birth of her fifth child. Uche lived with her husband and children and stated that she received family support while suffering postpartum depression. Nneoma was a typist and a mother of three. She stated that her third child was an unplanned pregnancy that happened when she was 41-years-old. She expressed that she did not experience postpartum depression with her other pregnancies. She received treatment for her depression. Ngozi was a supermarket manager and never married, but had three children by her high school sweetheart and she received therapy. Munachi was a seamstress with two children, and she became a widow when her last

child was 3-months-old. She received therapy for her postpartum depression and depended on her parents for help taking care of her children. Eziaku was a trader and mother of five. She was diagnosed with postpartum depression on her fourth and fifth childbirths and received pharmacotherapy and psychotherapy. Each participant was asked six open-ended questions to address the research questions.

Data Analysis

Ten participants answered the interview questions in individual, in-depth, face-to-face interviews. The interviews were audio recorded and were notes taken; the recordings were transcribed, and the transcripts were imported into NVivo9 for the data to be examined. The inductive coding method was used in data coding. The text was used as the source for coding, and the dominant themes were isolated and a range of themes were defined. According to Richards (2009), an inductive method does not need a development of a code book as it is not data driven. Data were explored for word frequencies and common ideas, and matrix and text coding were completed. The data coding comprised of reading the data transcripts, identifying expressive statements, and classifying data into nodes. The node classifications comprised of feeling and mood, coping, attitude, assessment, knowledge, help, support, and praying.

Six major themes emerged after the analysis of all transcripts. The themes were as follows: tearful and anxiety during and after pregnancy, inadequate assessment, stress, lack of knowledge, coping mechanism, and herbalist and prayer as recovery process. The theme of worry and weeping prenatal and postnatal appeared from the node classification

of mood and feeling, which had subnodes of worry, weeping, and mood. Insufficient assessment was the theme that appeared from the assessment node with a subnode of care provider conversation. The theme of emotion and tearful appeared from the attitude, which had subnodes of unfamiliar behaviors, weird contemplations, and unusual thoughts. The lack of understanding theme emerged from the understanding and support node with subnodes of family/friends support and health care provider support. The coping node had subnodes of need for respite, cure, and measures to lessen stressors. Prayer and herbs was a recovery mechanism theme that appeared from the prayer node.

Evidence of Trustworthiness

Efforts were made to ensure a lack of bias in data collection and analysis. The fundamentals of trustworthiness were significant to this procedure, which included credibility, transferability, dependability, and confirmability. Credibility was established through the provision of detailed information about the study to all participants and opportunity was given to each participant to ask me questions about the study before consenting to participate. Participants were assured of confidentiality and privacy; data collection was conducted in a private and secured area.

This gave participants the assurance that their participation was safe and secured. The areas were private and secured conference rooms with sound proofing. Participants were called on the phone for follow up to review the transcripts to ensure the quality of the evidence provided. Ashworth and Grassley (2009) described follow up with participants as needed to strengthen a study's credibility. Participant follow up permits

participants to authenticate that the information they provided was accurately replicated and translated. Transcripts and results were checked with 10 participants to confirm the accurateness of the data and discuss interpretation of data.

The follow-up calls also included feedback from participants on whether they felt that their privacy was maintained during the interview. Participants confirmed that the information they provided during the interview was accurately interpreted. There was no disagreement from any of the participants as to the interpretations and findings of the data. Detailed explanation of the study processes, including the participant recruitment process, data collection process, data storage and analysis, and study findings, were provided to participants to assure transferability, dependability, and confirmability. This will assist the reader in ascertaining the acceptability of the research procedures and assessing the trustworthiness of the study.

Findings

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, lack of understanding, needing to cope, and prayer and herbs was essential for recovery. A discussion of each of these themes follows.

Stress and Tearful Prenatal and Postnatal

Participants were asked to express their feelings during pregnancies and after their babies were delivered. Participants reported being tearful, lacking joy, strained, tense, and uneasy during their pregnancies. The feelings of unhappiness and sadness were increased

after the delivery of their babies, which increased their sensitivity to overpower. The study participants stated that they did not comprehend why there were tearful. Nevertheless, participants expressed concerns about taking care of their babies, ability to be a mother, and taking care of their families, which increased their feelings of unhappiness, hopelessness, and stress level. The unhappiness and emotional experiences of these women affected their doubt and anxieties about motherhood and raising their children.

Culture and Community Believe on Postpartum Depression

There were differences between participants' own experiences and their perception of their family and community beliefs about postpartum depression. The participants expressed feelings of devastating sadness, irritations, and stress and stated recurring experiences of crying, loneliness, and isolation. When the participants were asked about their family members and community response to postpartum depression, the participants stated that their family and friends believed that postpartum depression was a punishable belief, crazy, and shameful behavior. Eziaku expressed that her family and community understanding of postpartum depression as mothers that hear evil voices telling them to kill their baby and it's the result of evil spirit attack. There was a difference between what the participants expressed as the experience of postpartum depression and their thoughts of how their family and community recognized postpartum depression.

Participants stated that their family and communities believed that strong mothers do not have postpartum depression. According to the participants, their culture promotes the idea of the strong, self-sufficient mother. According to the participants, their community philosophy was that postpartum depression can occur when a woman is not strong enough to deal with the demands of mothering.

Munach stated that her family member said to her one day when she was feeling sad that

> Munachi that is your babble. There is nothing like postpartum depression for us, this is oyigbo man sickness. Ngozi: my sister said to me, depression is something young mothers like you do to get away from caring for their babies.

The participants in the study shared their stories about talking about their depression and anxiety to their families and communities, only to be met with judgements. Olanma stated, “Like if I had six children and I decided to get depressed, my friend and friends said to me, you should not open your legs to have babies and get depressed.” Some of the participants stated that having depressive symptoms after childbirth in their community was seen as being an unfit mother. Udoka stated,

> The people in my community make it seem like, if you are feeling depressed or depressed, you are flabby to be a mother. So, for you to go through how you feel, they believe that you should be able to handle it…. And this makes you feel like feeling the way you feel is a type of sickness that you just caught.

If any postpartum mother admits to being depressed, the family and community may see her as a flabby mother. These women would rather deny having these feelings than being labelled a flabby mother and being crazy. Munachi stated,

> I cried a lot when I was pregnant because I was feeling lonely, did not trust anyway and I kept for myself. It was the same when I delivered my child, it was a moment of joy and sadness, my feeling was like happy one moment, sad the next minute, everyone around was irritating me even my new baby. I was so unsure of her life and my family.

Olanma stated,

> I was not happy during my pregnancy, was very tearful and distressed , my emotion was sadness and unsure of myself , I was anxious about the pregnancy and taking care of myself and the family. I kept to myself, crying and sometimes calling names and when my baby was delivered the feelings increased.

Ngozi stated, "I never stopped crying, I cannot control my feelings, even now I cry sometimes. Thank God I'm taking medication now."

Insufficient Assessment

The participants believed that the assessment for their postpartum depression was insufficient or unduly assessed. Five of the participants stated that they did not remember their health care provider asking them about their emotion or feelings. It is possible to exacerbate the insufficient assessment and treatment of some women's postpartum depression (Sword et al., 2008).

Ada stated that her postpartum depression was diagnosed after several visits to the health center for complaining of not feeling well after giving birth. Ego described that her doctor was only focused on the antibiotics that she was receiving for her infection of her pubic area, and Munachi stated that the question was "how you are doing with being a new mom and breast feeding your baby and that was it."

Participants described their postdelivery follow-up visits as lacking proper assessment of their emotional and mental health. As a result of the insufficient assessment, interventions to address their postpartum depression were delayed. Four of the participants stated that they did not disclose their feelings to their health care provider when they were asked how they felt. Nneoma acknowledged that she did not inform her doctor about her feelings because she was afraid to be labelled as a mad woman. Ngozi and Ada stated that they did not disclose their feelings to their health care providers. Uche stated,

> I had a good doctor but I could not tell her how I felt. She suspected that something was wrong and persisted that I should open up and share with her what was going on. At that point, I decided to tell her how I was feeling and after a careful assessment she suggested that I see a psychiatrist.

Some participants expressed their unwillingness in revealing to the doctors their emotional state. This unwillingness to reveal their feelings may be a reason for their delay in the assessment and treatment they received.

Negative Feelings

Some of the participants stated that they had negative feelings and desires about themselves. They remembered feeling like they did not like themselves, negative thoughts, and lack of control of these behaviors. Participants stated that they had the strength and zeal to handle the activities of daily living. Eziaku stated,

> There were periods of time that I could be alone in the house, when everyone has gone to the market or farm, I will feel so scared, negative thoughts will feel my thoughts, thoughts of harming my baby sometimes, and sometimes feeling of rejection, or worthlessness. I will ran out of the house to my neighbor , who did not really understand what I was going through, she suggested that I was possessed by the evil spirit and need to see the herbalist or a pastor. Sometimes when I experience the negative feelings, I will yell out for no reason. My husband will be upset and ask if there is anything wrong with my brain that I should be yelling and disturbing the peace of the house. Sometimes, he will be kind to ask if I was in pain and reason for yell, if I'm seeing a ghost. My response would be I'm fine and not fine same time, I think something it's not right with me because my feeling is really strange.

Nkechi stated,

> Sometimes at night I will wake up and just sit steering up, sometimes pestering in the room asking myself why I feel sadness to the depths of my soul. Could not stop crying, even when there's no real reason for me to be in tears. I felt so

> hopeless, like the situation will never ever get better. You feel weak and defective, like a failure. I could not at night sleep when the baby sleeps, waking up in the middle of the night and can't go back to sleep no matter how tired you are.

The participants understood that their feelings and behaviors were strange, but were confused about the cause of the strange behaviors. They felt helpless and a lack of control of their behavior that affected their daily lives and family members, which ultimately added to their distress.

Absence of Understanding

Participants expressed that an absence of understanding about postpartum depression as a factor in their confusion about what should be disclosed to their health care provider. Nneoma said:

> I was not open to my health care providers, I refused to ask questions about my negative emotion and feelings. I refused to inform my doctor about the way I feel even when she asked me how I feel. I did not tell because I was afraid of his conclusion and see me as a mother afraid of motherhood.

Munachi and Ngozi described being affected by inadequate discussions about postpartum depression during their pregnancy, and they stated that they still lacked a full understanding of the issue. Other participants stated that the lack information on postpartum depression contributed to their emotional problems. While Uche also felt that she did not understand what she was feeling, she did believe that her health care

providers offered her with a description of what she was feeling. A quotation from Uche's response is documented below.

> When I asked my doctor why I feel the way felt and why do I have to go through the emotional problem, she said to me that some women do go through some mental or emotional problem after giving birth but she did not make it clear to me that this may need treatment at that time but continued to say it's something women go through after delivery. The lack of understanding of postpartum depression by the these women is obvious as a result of the health care providers missing the opportunity of timely assessment and diagnosis and referring them to psychologist or psychiatrist for treatment.

According to Norhayati et al., (2015), some providers had difficulty categorizing postpartum depression, and the only action they could recommend was referral to another provider. Likewise, family,friends, and especially spouses may struggle to understand postpartum depression. Nkechi said:

> When my family and other family members observed that I was not same behavior, none care to do something or ask the doctor what to do, they thought I was pretending and nothing was wrong with me. My grandmother said to me that you need to be able to parent in the same way I did and your mother too and stop acting the way you are acting. I believed that my family and friends considered my problem as involving extreme thoughts and crazy, dangerous behaviors.

Coping Methods

Participants had difficulty coping with the emotions they experienced. Four participants, Elizaku, Nkechi, Ada, and Udoka, stated that they looked for coping mechanisms on their own because they felt that their feelings were not addressed properly in their initial visits. Ngozi, Munachi , Nneoma, Ego, Olanma, and Nkechi all said that they felt that something was wrong and wanted to get better but knew they were powerless to solve the problem on their own. Olanma went to the hospital one morning, saw the doctor and was stated on medication. Munachi went to the health center close to her home, where the nurse recommended seeing a doctor at the postpartum clinic. She followed that advice, and the doctor she saw recommended pharmacotherapy after she explained to him how she was feeling.

Nkechi stated that because she was in need of a coping mechanism, she continued to take over-the-counter medication to aid with sleeping at night. Ego expressed loneliness that came with her feelings, and she was open to any kind of help to help her feel herself again. "I'm glad that I was able to find help and I'm doing everything I have been asked to do because I want to be healed completely." Ngozi said:

> Before I found the help that I needed, I was unable to take care of myself, my baby and never wanted to do anything with anyone, hated the world but now I'm feeling the joy to life , doing my daily obligations and so happy taking care of my new baby and raising my other kids. Thanks to the doctor who recommended my treatment plan and encouraged that I followed through.

Recovery through Prayer and Herbs

The prayer theme emerged from six participants, and the herbalist theme emerged from two participants. These participants recognized the need to seek help through prayers and herbalist mediation. They believed that these interventions were more effective for their needs. Ego stated:

> As a Christian, I knew that prayer could be a solution to my problem. I decided one morning to talk to God about my problem through prayer. I also consulted my pastor, who recommended that I continue to pray and trust in God for healing. My mother was afraid that my emotional problem could result to hurting myself or my baby. She also recommended that I join her prayer group. Going to church helped me a lot, but it did not take the problem away completely.

Udoka expressed similar feelings about her use of an herbalist:

> When I could not get help from anyone, I followed the suggestion by relative who advised me to seek help from the herbalist, the herbalist gave me some herbs to use twice a day. The herbs did not help me at all, it did not make me feel any better, and thank God I stopped taking that herbs. I went to my pastor and asked him to pray for me, he has been praying for me and that was more effective than the herbs and even the medicine I was taking.

Munachi found support with her church:

> Going to my church and asking my pastor and the prayer group in my church helped me a lot to feel better. The first day I told my pastor about my problem, he

> told me that there is nothing prayer cannot do, that I need to ask God to heal me but you need to have faith he said. Truly the prayer and the medicine really helped me feel a lot better. I felt better after my church people prayed for me, better than I felt when I was just taking the medicine with not prayers.

Summary

This chapter described the data collection storage, analysis, and verification process used in the study. The findings of the study were reported within the frame of the research questions. The following themes emerged from the answers to the interview questions: stress and weeping prenatal and postnatal, insufficient assessment, negative emotions, absence of understanding, coping mechanisms, and prayer and herbs as an indispensable recovery method. The participants reviewed the results of study through follow-up phone calls. All participants responded to the follow-up phone calls and confirmed the results. The interpretation of the study findings, implications for social change, recommendations, and conclusion are presented Chapter 5.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

In this study, I sought to obtain an understanding of the lived experiences of the assessment and treatment processes for Imo State women who suffered postpartum depression. I examined the women's experiences of the assessment and treatment they received. The research questions for the study were as follows: How do Imo Nigerian mothers perceive assessment of mental health during pregnancy? What is the lived experience of the assessment and treatment procedure for Imo Nigerian mothers with postpartum depression? To what extent do Imo Nigerian mothers perceive their emotional needs have been met during post-natal visits? What are common attitudes regarding assessment of stressful events experienced by Imo Nigerian postpartum mothers?

Ten Imo State women were recruited to participate in the study. These women depicted their experiences of postpartum depression, the signs and symptoms they experienced, the diagnostic process, and the treatment received. The empowerment theory was used to develop the interview questions. Six themes (prenatal and postnatal anxiety and crying, inadequate assessment, negative feeling, culture and absence of understanding, coping mechanism, and herbs and prayer as recovery methods) emerged from the answers to the interview questions. All 10 participants responded to the follow-up phone calls to confirm the findings of the study.

Interpretation of Findings

In the findings of the study, I found that the participants did not believe that the assessment and treatment procedures for their postpartum depression were sufficient. They felt that their emotional needs were not properly managed. They expressed the anxiety they experienced; the inability to cope; and the effects it had on them, their family, and activities of daily living. The participants described being tearful during the pregnancy and observed that it increased during the postdelivery. The feeling of hopelessness is one of the symptoms presented by women who experience postpartum depression. Other symptoms they reported included a lack of interest in activities of daily living and refusal to welcome visitors to their homes. The widows and the unmarried participants did not discuss receiving support from spouses or significant others, two participants described their partners as helpful, two participants described their relationship with their partners as not supportive or caring, and four participants described their spouse as supportive as Igbo men in general are known for their caring heartedness towards their wives especially during postnatal. Three of the participants were widowed, and they reported how difficult it was to care for themselves and their kids, and their low income was adding to their stress level and they sometimes felt like ending their lives.

The barriers to assessment included the difficulties the participants had discussing their health problems and mood with their doctors. Almond (2009) observed that women see their health care provider's behavior as a barrier to receiving treatment for postpartum

depression. The participants felt that others, including their doctors, would regard them as mentally unstable, which would lead to an inability to care for their newborn, as well as themselves. The participants expressed that their doctors showed no sign of empathy or concern for the symptoms that they experienced. They stated that their doctors mainly focused on their babies and disregarded their feelings, assuming it was related to childcare and the delivery process. The women stated that the signs and symptoms they possessed were not properly assessed, along with untimely treatment suggestions. This led some of women to seek help and treatment from the local herbalist once the symptoms worsened and some help from their local community churches.

Participants also reported a lack of understanding regarding their problems, and they struggled with they should or should not disclose their problems with their family health care provider. According to Almond (2009), a lack of recognition and proper treatment of postpartum depression increases the likelihood of postpartum depression and the reluctance to seek help. Almond also suggested that family members' and health care providers' lack of understanding of these women have led to a failure to timely asses and treat these women. The lack of recognition and proper treatment of postpartum increases the likelihood of postpartum depression and the reluctance to seek help (Corwin & Arbour, 2007).

Limitations of the Study

One of the limits to this study was the difficulty of recruiting participants who were willing to share their experiences of postpartum depression. It was assumed that

individuals experiencing mental disorders are concerned about being labeled as "fanatical," which may lead to a problem in recruiting volunteers for the study. Horowitz and Cousins (2006) observed the impact that fear of stigmatization can have in decreasing treatment rates; some women may fail to discuss their feelings or fail to seek treatment. The participants may not want their interviews recorded in spite the guarantees of confidentiality and privacy. The second limitation to the study was that the findings could not be generalized to all women experiencing postpartum depression.

This study provided some understanding into Imo State women's experience of postpartum depression. It is important for health care practitioners to assess each woman and provide an individualized care based on each woman's individual needs and desires (Henderson & Redshaw, 3013). Also, this study was a phenomenological examination and did not provide quantitative reports of postpartum depression. The study findings were limited to analysis of identified themes. The possibility of introducing response and interviewer bias into the study was considered a possible limitation.

Recommendations for Further Study

In this study, I addressed the study participants' experience of the assessment and treatment processes for postpartum depression. Although postpartum depression has been documented as a problem, there is a continued lack of information about postpartum depression among postpartum women. This gap in knowledge suggests the need for further study about better approaches for getting women appropriate care for their postpartum depression. Study participants may have gained information from prenatal

and postnatal discussions about postpartum depression with their health care providers. The experiences of postpartum depression for partners, families and community members of these women have not been well-documented, and this gap in knowledge could be the reason for the lack of assistance from spouses and companions. More study is needed about the impact of pregnancy and prenatal postpartum depression education on women's motivation to reveal their postpartum depression. More study is also needed on community education about postpartum depression and on Imo-State men social and cultural support for Mothers with Postpartum Depression. Need for assessment of other family members, partners can provide useful information in assessing for and treating postpartum depression and should be viewed as potential targets for intervention. Culturally relevant education about postpartum depression could increase awareness and reduce stigma and misconceptions among people in their communities.

Participants in the study expressed being worried experiencing stress. Further study is needed on the relationship between stressful life occurrences, social support, and postpartum depression. Because a significant limitation in this study was the difficulty in recruiting participants, the obstacles to recruiting participants for studies on postpartum depression and other mental health problems could also be examined in future research.

Implications for Social Change

Answers from the participants in this study showed that they experienced emotional distress, and they struggled to cope with the feelings they experienced. They found assessments of their emotional states during their prenatal and postnatal visits to be

insufficient. They also did not receive enough assistance from caregivers and sometimes from family members. These findings can be used to assist women's healthcare providers in understanding the experiences of postpartum depression so that appropriate and timely care can be provided. This understanding should help increase public knowledge on the kind of difficulties these women experience.

The results from this study can help to enhance awareness of factors that should be considered in the assessment and treatment of postpartum depression. These factors include the lack of knowledge about postpartum depression that some women may have and the potential difficulty they may experience in disclosing their feelings to their health care providers. The understanding obtained from this study can be used to enhance awareness for women with postpartum depression so that they seek help from their providers. The results can also help providers to design relevant assessment tools for postpartum depression.

Postpartum depression assessment reminders can also be added to discharge instructions for postpartum mothers. Some organization have developed guidelines and screening tools for identifying women who may be at risk, such as the Edinburgh Postnatal Depression Scale (EPDS), the Postpartum Depression Screening Scale (PDSS), and the Patient Health Questionnaire (PHQ-9). The experiences of the study participants confirmed that these assessment tools for postpartum depression are not consistently used. The findings of this study should be disseminated to the interdisciplinary team of health care professionals who provide care to pregnant and postpartum women. The

findings form this can be used by the health care providers to provide education on postpartum depression, assessment and treatment.

Researcher's Reflections

As stated in Chapter 3, my younger sister is married and has four children. She experienced postpartum depression with her third child. It seemed to me that there was a lack of understanding of her condition on both the part of professionals and the people in Imo-State and that lack of understanding led her to be marginalized, misdiagnosed and unsupported. Although the body of scientific literature has led to an increased understanding of postpartum depression, the condition continues to be underdiagnosed and insufficiently treated. I believe that women experiencing postpartum depression should be provided with proper treatment. Should a failure in diagnosis or insufficient treatment result in mother killing her infant, I do not think she should be seen as a criminal and face prosecution; rather, she should be treated as victim of circumstance. I have provided care to mothers with postpartum depression in my career as a nurse. I was astonished at the depth of emotions expressed by my study participants and by the courage they showed in sharing their experience. The reason I chose postpartum depression for my research is that it seemed to me that many postpartum women do not understand the severity of postpartum depression and the importance of seeking treatment.

Many of the women I interviewed thought that depression after childbirth was normal. The heartbreaking consequences these women experienced resulted from a lack

understanding and support. During my experience gathering the information from these women, it occurred to me that if they had not received treatment, many worse consequences would have. In identifying common themes for the study, I also thought about the individual experiences of each participant. I wondered at the fact that although postpartum depression has been extensively documented in the scientific literature and several health care professional organizations have prioritized recognizing the signs and symptoms, the disorder continues to be underdiagnosed and inadequately treated. I conclude that postpartum mothers need a timely assessment for postpartum depression, and treatment must be provided as soon as diagnosis occurs. I believe that failure to do so results in negative effects for these women, their babies, and their families.

Conclusion

The findings of this study indicate that the participants felt that the assessment process for postpartum depression was inadequate, and this inadequacy had resulted in delayed treatment. In order to cope with their emotions, several participants sought treatment on their own. Participants also reported increased crying and stress during and after their pregnancy. Some experienced behaviors and thoughts that were out of the ordinary, and felt a lack of understanding and support around these symptoms. 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 hesitation to inform their providers of distressed moods and. Providers should be educated about this reticence so that they can find strategies to help women to disclose.

The impact of postpartum depression goes beyond the mothers and is shared by children, partners and other family members, and society as a whole. This far reaching impact of postpartum depression makes it a significant public health issue.

It is hoped that the findings will help to increase women's knowledge about postpartum depression and encourage them to seek help. It is also hoped that healthcare providers will use results from this study to reinforce their practice of caring for women at risk for postpartum depression. Maternal healthcare providers need to be informed of the scope of postpartum depression and its potential for lasting harmful effects on both the mother's well-being and the child's development. An assessment program for postpartum depression should be included into the routine postnatal care of mothers. This would help to identify mothers with postpartum depression for prompt psychiatric evaluation and treatment. The cause of postpartum depression remains a challenge, but the misery and depressing effects of postpartum depression can be decreased with early assessment and treatment. The prevention of the effects of postpartum depression is possible through increase in awareness of the disease.

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Appendix A: Interview Questions

Interview Questions

1. Describe the feelings you felt during your pregnancy and the weeks after your baby was delivered.

2. How would you explain your interaction with your family and your nurse or doctor when you are feeling bad and unhappy? What of kind of suggestions do your nurse or doctor give when you are feeling unhappy?

3. In what way does talking about your being unhappy or sad make you feel? Do you think that the nurse or doctor understands why you unhappy or sad?

4. Describe your experience when saw your nurse or doctor after your baby was delivered. How did the nurse or doctor check your feelings or emotions?

5. What type of questions did your nurse or doctor asked about your mood?

6. What did your nurse or doctor do or tell you about your mood?

7. What do you think about your conversation with your nurse or doctor about your how you were feeling?

8. How would you describe your involvement in the assessment and treatment for how you were feeling?