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Depression With Peripartum Onset (Postpartum) and Mother's Perceptions of Social Support and Self-Efficacy for Parenting

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Abstract

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by

Shenetha Carmise Ramsey

MSW, Southern University at New Orleans, 2009

BSW, Southern University and A & M College, 2005

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Depression with peripartum onset, which was previously called maternal depression, or postpartum depression, is common among many pregnant women. The condition increases impairment in maintaining relationships, self-esteem, and parenting skills. The purpose of this phenomenological qualitative study was to explore how mothers who have experienced peripartum onset (postpartum) depression perceive their social support and their ability to parent effectively. The conceptual framework was based on Albert Bandura's self-efficacy theory. Convenience and snowball sampling were both used to obtain 6 research participants who were interviewed face-to-face or by telephone. Participants shared their experiences with depression, perceptions of social support, and how both influenced their parenting efficacy. Two cycles of coding were used: initial and focus coding. Key themes of this research study were mother's age of onset with depression, symptoms, coping strategies, supports received, results of social supports, recommendations to other mothers, and effects of depression on parenting. The results were that mothers' depression negatively affected parenting, which resulted in receiving social supports such as postpartum trainings, talk therapy, and psychotherapy (counseling). This study may help to close the gap and extend the literature by exploring the influence of peripartum onset (postpartum) depression on parenting. Implications for positive social change may include more direction in how human services professionals address mothers during their pregnancy or postpregnancy related to peripartum onset (postpartum) depression.

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Dedication

I dedicate this dissertation to my family, my hardworking parents Joe L. Ramsey, Sr. and Clara M. Rogers-Ramsey and my dear siblings Sharon R. Ramsey, Karen L. Ramsey and Joe. L. Ramsey, Jr. There were times I had to say no when you needed me. I even had to miss some family time. You knew that this doctoral journey was very important to me and very demanding. I thank you for your understanding and support. Lastly, to my wonderful nephews, Karon L. Gilmore and Cam'ron J. Quinn, thank you both for being my sunshine on my toughest days. You too will succeed. I love you all.

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First giving my obedience to God, the great head of my life. *"I can do all things through Christ which strengtheneth me"* (Philippians 4:13, KJV) is very encouraging. To my dissertation committee Dr. Pamela F. Denning (Chair), Dr. Scott L. Hershberger (Methodologist) and Dr. Tina F. Jaeckle (URR), I thank you. Thank you, Dr. Evelyn M. Britton (Academic Coach/Mentor) and Dr. Avon M. Hart-Johnson (Doctoral Consultant and Walden Faculty). I would also like to thank you Dr. Roslyn C. Richardson and Dr. Patricia L. Smith for your words of encouragement and support. Although the journey was long and demanding, I learned a lot along the way. I appreciated having the opportunity to achieve a higher degree with a higher purpose. I thank all of the mothers who participated in this research study, because without your support this project would not have been completed. Thanks to everyone who supported me and who did not doubt me and shared positive words.

I am sharing a scripture with others who are on their educational journey or who are aspiring to achieve a higher degree. *"The race is not to the swift, nor the battle to the strong"* Ecclesiastes 9:11, KJV. This means, you can make it if you keep the faith and press through the storm and the rain.

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Chapter 1: Introduction of the Study

Introduction

Clinical depression, also named peripartum onset depression, affects 10% to 40% of mothers with young children and may have negative consequences for their children's health and development (Kerker et al., 2016). According to Sharma and Mazmanian (2013), some women experience depression during early pregnancy as a result of discontinuation of antidepressants, whereas others may experience the first onset of depression during pregnancy (Wisner, Sit, & McShea, 2013). According to Chojenta, Lucke, Forder, and Loxton (2016), more than 15% of women experience depression with giving birth to at least one child. These women are most likely to be teen parents, have a lower socioeconomic status, and have avoidant coping behaviors (Steeger, Gondoli, & Morrissey, 2013). Morgan, Shaw, and Forbes (2014) found that lack of maternal warmth during early childhood is associated with less activation in the child's medial prefrontal cortex (mPFC); therefore, it is reasonable to assume that the well-being and mental health of the mothers are critical not only to them, but also to the healthy development of their children. Likewise, Katz, Hammen, Constance, and Brennan (2013) found that the offspring of depressed mothers are at a greater risk for adverse psychopathological and psychosocial outcomes than children of nondepressed mothers.

In this research study, I explored how women who were diagnosed with peripartum onset (postpartum) depression perceive their parenting skills. In this research study, I have provided additional insights into and understanding of the effects that

depression has on the mother-child relationship as well as an increase the understanding of a mother's perception of her parenting skills and help researchers to better understand the mother-child relationship. This understanding may assist professionals to engage mothers dealing with depression in an awareness of her parenting skills and to develop strategies and interventions to strengthen her relationship with her child. Through this study, I may also provide program developers with an understanding of how mothers perceive their own parenting abilities and how that affects the mother-child bond.

In this study, I have extended the work of Hamall et al. (2014), who examined maternal depression and indicated that there was a need to understand parental efficacy. I expanded on this literature by exploring perceptions of parenting mothers who were diagnosed with clinical depression also named depression with peripartum onset. I engaged self-identified research participants who shared their experiences with depression and perceptions of social support, and how both influenced their parenting efficacy.

Background of the Study

Researchers have identified factors that cause depression in mothers and how it affects the mother-child relationship (Bosquet & Egeland, 2001). Maternal depression may develop from stressors that are common in women, which relate to biological factors and environmental factors (Thompson, 2006). Depression among mothers is an often-studied dimension, but additional research is needed to address gaps in the literature (Mennen & Trickett, 2011). Examining maternal depression and its effects on parenting skills is vital because it affects so many mothers. According to Burke (2003), the

inadequate parenting skills caused by depression may result in impairment among children. Steinberg (2004) found that adequate parenting requires mothers to be aware of their children and their needs, and also aware of their own ability to provide the necessary attention to a child to maintain an acceptable relationship. This may be a challenge for the depressed mother.

Depression may lead to suicide attempts, higher health care costs, increased death rates, and morbidity (World Health Organization, 2001). According to Feder et al. (2008), many children of depressed mothers tend to develop increased psychosocial problems. Gerkensmeyer (2008) found that mothers are most often the parent or caregiver who becomes depressed. Maternal depression affects the mother, the child, and potentially society as a whole. According to Newton (2008), children who receive the necessary parenting from their mothers are considered secure, which reflects a better ability to learn and adapt to others. Therefore, children who do not receive the necessary parenting from their mothers are deemed to be insecure-avoidant and ambivalent, which results in an inability to regulate emotions (Newton, 2008). According to Newman and Newman (2003), a mother's perception of her parenting skills is important because a positive view of her ability to parent increases the trust between a mother and her child(ren) (Jha, 2016). According to Meleis (2007), maternal depression is the result of a lack in stability, certainty, and vulnerability. Maintaining connection between self and others can prevent the causes of distress and withdrawal (Mauthner, Stoppard, & McMullen, 2003).

The research study by Leahy-Warren et al. (2011) reflects that the gap in the literature identified still exists. Leahy-Warren et al. found through using Bandura's framework, that adequate parenting increases better well-being among parents and their children. What is missing in the qualitative phenomenology research is: How do mothers diagnosed with peripartum onset clinical depression perceive their parenting skills? Social support relates to the sufficient care provided to parenting figures provided by others. In this study, I extend the work of Madison (2014), who also examined maternal depression and indicated a future need to understand parental efficacy as it relates to the influence of depression and the role of social support networks.

Problem Statement

A study of maternal depression is significant because of its frequency and adverse possible influence on parenting and children (Cummings & Davies, 2006). This study may provide the necessary data to better understand this research problem from a qualitative perspective. According to Cummings and Kouros (2009), parenting has become a major concern because of the global changes that affect parenting and the relationship between the mother and her child(ren). The term *global* pertains to the social issues that are considered universal or worldwide. The global effect included are behavior, socioemotional adjustment, and emotional regulation in children (Herba et al., 2016). Herba et al. found that these global effects indicate that during pregnancy, maternal depression could affect child outcomes through altered placental function, epigenetic changes in the child, and stress reactivity. In this study, I also link maternal depression to inadequate parenting and discipline. Finally, less parenting control and

poor-quality relationships between the mother and her child(ren) seems to cause dysfunction as evidenced by other research findings (Cummings & Kouros, 2009).

Purpose of the Study

My purpose in this phenomenological qualitative study was to explore how mothers who have experienced peripartum onset (postpartum) depression perceive their social support and their ability to parent effectively. Through this study, I may contribute to the field of human services by informing and educating professionals in the field. Mothers and family members would also benefit from this contribution because it will educate them about how to intervene and when to seek assistance. When mothers and family members know when and how to intervene and seek the necessary assistance and how to contact health care professional(s), who specialize in peripartum onset depression, the outcomes improve. Human services professionals will be able to reflect on the impairments that stem from depression and design programmatic solutions for this group of women. Tailored services such as consultation, counseling, and/or parenting classes may be viable options.

Haung (2014) found that a lack of social support results in parental stress and negative mental health, which stems from depression, results in reoccurring adverse effects on children. Compounding this issue is the lack of postpartum care, which may result in depressive symptoms (Haga, Lynne, & Slinning, 2012).

Inadequate mastery of parenting skills may also manifest in a feeling of lack of control and having unfulfilled expectations and ultimately may affect the mother-child

relationship as well (Haga, et al. 2012). This study may increase understanding of how mothers perceive their social support as affecting their ability to successfully parent.

Research Question(s)

How do mothers diagnosed with peripartum onset clinical depression perceive their parenting skills?

Nature of the Study

I used this phenomenological qualitative study to explore the experience of parenting mothers older than 18 years who are parenting child(ren) younger than 12 years, who have experienced depression related to their self-efficacy as parents based on levels of social support received. In this study, research participants were women who were diagnosed with peripartum depression. Mothers self-identified as meeting the criteria of this study. I assumed that to request substantiation through medical records or other proof of diagnosis may be a violation of privacy and possibly against Health Insurance Portability and Accountability Act (HIPAA) rules.

Patton (2002) indicated that with phenomenological studies, the foci are placed on emotions, relationships, or programs as a qualitative inquiry. However, qualitative research studies have examined variables unique to depressive symptoms by using instruments such as the Parental Relationship Questionnaire, or the Edinburgh Postnatal Depression Scale (Haga et al., 2012), to detect depressive symptoms in new mothers. In this study, I extend this work by exploring qualitatively how social support may affect a mother's secure attachments, from the perspectives of these women.

Prior phenomenological studies have typically included the seminal work of Husserl (1913). The author believed that phenomenology is largely composed of how participants describe and experience a phenomenon in their lives. By using the qualitative research method, I prepared semistructured interview questions that are aligned with my research question. Further, I extend these interview questions to explore aspects of my conceptual framework based on attachment theory and self-efficacy theory. To understand in-depth experiences, a researcher must garner the answers that describe them, in detail, in a manner that reveals a shared experience across a group (Van Manen, 1990). During qualitative interviews, hermeneutics will provide insights specific to the participant narratives, whereby interpretation is within the tradition of the family support network, researcher subjectivity, and hermeneutic context (Patton, 2002). To learn the necessary insights from these participants, I interviewed six self-identified parenting mothers who were diagnosed with depression at the peripartum stage. I analyzed the data, searching for clusters and themes that represent the common phenomena of mothers who were diagnosed with peripartum onset depression their and perceptions of self-efficacy based on their social support.

According to Rudestam and Newton (2015), convenience sampling fits this phenomenological qualitative study because it narrows the analysis so that the feelings and attitudes of the group diagnosed with peripartum onset depression will allow in-depth evaluations in a quality assurance effort. An experimental design is not feasible for this study because it will not use a control group and will require the randomization technique. It is not practicable to do an experimental design without a control group and

randomized sampling. In this study, I selected research participants not by choice but rather by chance (Patton, 2002). The qualitative research method should help in attaining the necessary data from self-identified parenting mothers who meet the criteria.

Keywords and Definitions

I use following keywords and definitions throughout this study.

Attachment: The connection that builds a relationship (i.e., the bond between child and caregiver) (Bowlby, 1978).

Children: Youth younger than 12 years; son or daughter of a biological parent, guardian, or stepparent (Merriam-Webster, 2013).

Depression: In this study, this term is defined as clinical depressive disorder and is also known as major depressive disorder. There are multiple symptoms that fit depressive disorder, but I am describing the five that are common in many people including mothers. The five are (a) depressed mood, (b) loss of interest or pleasure, (c) fatigue or loss of energy nearly daily, (d) feelings of worthlessness or excessive or inappropriate guilt (may be delusional each day and/or feel guilty about being ill), and (e) diminished ability to think or concentrate, or daily indecisiveness. These five factors of depression affect the mood daily and are obvious to others. I did not use an instrument to diagnose the research subjects; however, they self-identified themselves as depressed to participate in this study. This was a self-report by participating mothers (*DSM-5*, 2013).

DSM-5: The *Diagnostic and Statistical Manual of Mental Disorders* that is used by mental health professionals and clinicians to properly diagnose patients (*DSM-5*, 2013).

Maternal: An attribute pertaining to a mother or female parent figure (Merriam-Webster, 2013).

Mother-child relationship: An intimate connection between the mother or caregiver and the children (Azar, 2009).

Assumptions

As the researcher, I expected each research participant to provide true responses to each question presented to them throughout the data collection phase. Next, I constructed my study on the assumption that behavioral science theories accurately detail the nature of a mother-child relationship and thus are pertinent. Another assumption is that my sample may have been challenging to obtain because of the stigma against mothers who experience depression. Last, I narrowed the unit of analysis to previously depressed mothers older than 18 years who are parenting at least one child younger than 12 years. The demographics such as age and common social issues among parenting mothers are important to include in the analysis because this result in clear findings. Furthermore, using theoretical sampling, the proper balance of data would be produced for qualitative data analysis and understanding to shape theory is a limitation (Ritchie & Lewis, 2003).

Scope and Delimitations

In this research study, I focus on maternal depression and how it affects parenting in the mother-child relationship. Six English-speaking mothers older than 18 who have experienced peripartum onset depression and who are parenting at least one child younger than 12 were included in this study. These eligibility requirements for research participants help the study reflect as accurately and feasibly as possible the representative group under study. This approach may narrow the focus from general to specific, whereas the details are supported by evidence via observations.

Limitations

There are three limitations of this qualitative research study. The convenience sample was a limitation, which is smaller in size than an experimental sample. I posted flyers in various mental health clinics to recruit research participants for this study. The biases that could influence the study's outcome are a research participant's subjective responses on the questionnaire. Third, when some research participants feel uncomfortable with a certain question on a questionnaire, they may not answer the question truthfully or at all. According to Altheide and Johnson (2011), reliability proves that the research is replicable; those who are interested in this subject area of research can do further studies. Reliability should not be affected by the mother's response because the interview questions should be nonbiased, which allows for better research findings. Reliability in qualitative research can be addressed in various ways, but the researcher must obtain complete field notes, a good-quality tape for recording and accurate transcription (Silverman, 2013). When the researcher maintains the data properly,

cleaning and coding seem less cumbersome. Although some parents may be motivated to report inaccurately to look like ideal parents, the questions are unbiased, sensitive, and specific. Sometimes, incomplete responses may be irrelevant and thus cannot be considered. The biases that could influence the study's outcomes would be using the incorrect sample or incorrect analysis (Vogt, Vogt, Gardner, & Haeffele, 2014).
As a result, the reasonable measures to address limitations would be to use unbiased terminology and include evidence that correlates with the literature of the study.

Significance of the Study

This research study may result in a positive change by contributing to the field of human services and providing information for clinical professionals. For example, programs providing direct and indirect services to women and children, and clinicians who provide counseling and consultation services to mothers diagnosed with depression would benefit from the study, resulting in positive change. Weinstein (2010) defined *social change* as concerned with the dynamics, rather than their area of expertise within the profession of human services. Social changes may include but are not limited to developing programs and providing services to assist the disadvantaged populations. This study is significant because I focused on the mother's perception of her parenting skills. This study will allow mothers to share their experience with depression, and it also may contribute to the profession and educate those in other fields of study, such as education, mental health counseling, psychology, rehabilitation counseling, sociology, or therapeutic recreation. These professions can benefit from the value added to existing research. The current study can be replicated by other researchers who are interested in

this field and the population it affects. This study may also influence other professionals to research how to better educate parenting mothers who have experienced depression. Both new and experienced mothers need to be aware of how depression can negatively affect parenting and their relationship with her child. Maternal depression can affect mothers throughout pregnancy, after childbirth, and while parenting their child(ren). The mothers who participated in this study interviewed to share specific experiences with peripartum onset depression and their feelings or attitudes toward social supports, and how both influenced their parenting.

The potential implications of social change pertain to mothers who are diagnosed with depression and who suffer from stressors that cause an increase in inadequate parenting and child supervision. The implications are at the microlevel of social work, which reflect whether depressed mothers are receiving the necessary treatment and/or consultation from human service professionals. Those parenting mothers also benefit from a stronger relationship with their spouse or significant other, so that there is a quality mother-child relationship. More effective parenting skills and best practices can be given to depressed mothers to encourage effective parenting. Moreover, moderating factors of research is needed about depressed mothers and parenting skills to offer better prevention and efforts of treatment to mothers who are considered at-risk. Furthermore, comprehensive efforts to intervene in a timely manner and help mothers, children, and families may have an impressive and vital influence on the development of children.

Summary

The essential information of this chapter reflects maternal depression as a social problem and emphasizes that depression negatively affects the mother, child, and other family members. In Chapter 2, I provide prevalent and incident information as it relates to maternal depression and parenting skills. This chapter is important, because it helps to understand the literature of depression among parenting mothers. In Chapter 3, I discuss my research methods. This chapter is also important because in it, I provide a definition of the research method used along with the reasoning for its use. In Chapter 4, I explain the findings of this research study, which relate directly to the methodology that I describe in Chapter 3. I explain the procedures and specific tasks that I completed in depth for a better understanding of the analysis of this study. Last, in Chapter 5, I summarize, conclude, and provide the implications of this study. Implications provide concluding details that discuss the outcomes of the research study. Moreover, in Chapter 5, I include a review of the research study along with other factors and/or recommendations for those who are interested in further research.

Chapter 2: Literature Review

Introduction

In Chapter 1, I included an overview of the issue of depression among parenting mothers. In this chapter, I will review the literature on depressed mothers and the effects of maternal depression on parenting skills and the well-being of mothers and their children. My purpose in this study was to examine the experiences of mothers who self-identify as being diagnosed with peripartum onset depression. I designed this phenomenological qualitative research study to understand parenting mothers' experiences with peripartum onset depression, the social supports they received, and their perception of their efficacy as parents. To examine this problem, I discuss the literature on the theoretical foundations that support this study. I also discuss the history of depression and the effects of maternal depression on children. Next, I cover how women perceive social support and its effect on parenting and self-efficacy. Finally, I summarize the literature.

Literature Search Strategy

I used a systematic approach to research the literature specific to maternal depression and its possible impact on parenting. The library databases used for this research study were EBSCO, Academic Search Complete, ProQuest Central, and ScienceDirect. I used keywords, including *attachment theory, inadequate parenting, maternal depression, parenting styles, peripartum onset depression, self-efficacy theory, social support,* and *uninvolved parenting theory.*

Conceptual Framework

The conceptual framework that correlates with this study is the self-efficacy theory. According to Cherry (2016), Bandura developed the self-efficacy theory believing it could help prevent relapse to negligent behavior. This theory emphasizes the role of observational learning, social experience, and reciprocal determinism in the development of personality. Moral judgment and physiological arousal research are primarily focused on self-efficacy, or one's beliefs or ability to successfully complete tasks or fulfill roles (Locke & Latham, 2002). According to Ramachandran (2012), self-efficacy theory was developed as part of a larger theory, the social cognitive theory. Social cognitive theory integrates a continuous interaction between behaviors, personal factors including cognition and the environment, referred to as reciprocal causation model (Bandura, 1977). Bandura (1977) defined *self-efficacy theory* as a concept that is assigned a significant role for analyzing changes achieved in fearful and avoidant behavior. This theory was based on the principle assumption that "psychological procedures, whatever their form, serve as a means of creating and strengthening expectations of personal efficacy" (Bandura, 1977, p. 193). Self-efficacy theory deals with what people believe they can accomplish using skills under certain circumstances. This theory fits my study's conceptual framework, because it provides a description of how social support and self-efficacy is interchangeable; meaning both concepts have an influence on mother's ability to parent. Self-efficacy theory reports on the level of persistence a person will exhibit to learn a new and challenging task, with the end result of gaining confidence (Bandura, 1982).

Self-efficacy theory focuses on an individual's belief in his or her capabilities to organize and execute the courses of action required to manage prospective situations. This theory also reflects the mother's confidence to parent effectively (Bandura, 1995). Bandura (1994) determined that self-efficacy theory is important to parenting because having self-efficacy increases the quality of mother-child relationships. The impairment of a child's academic achievement and the expression of negative behaviors also stem from lack of parental self-efficacy (Bandura, 1977).

Several research studies have examined the relationship between self-efficacy theory, parenting, and outcomes for children. Masud, Ahmad, and Jan et al. (2016) conducted a research study in Pakistan that pertained to self-efficacy theory and adolescents where there had been a gap in research and lack of measurement of the relationship between parenting styles and the teen's academic performance, with parental self-efficacy as the mediating variable. A total of 313 university students from four academic departments were included in this research study. Parenting styles and self-efficacy were the two concepts measured and the study found that parental self-efficacy is related to the academic confidence of the next generation and that there is a need to conduct more research on the relationship of parenting styles and academic performance in Pakistan.

Yap and Baharudin (2016) completed a research study including the self-efficacy theory. The purpose of their study was to examine the mediating roles of academic self-efficacy, social self-efficacy, and emotional self-efficacy on the relationship between

parental involvement (i.e., paternal involvement and maternal involvement) and subjective well-being (i.e., positive affect, negative affect, and life satisfaction) of Malaysian adolescents. A total of 802 Malaysian high school students between 15 and 17 years old from 14 public schools participated. Results of a multiple mediator model indicated that academic self-efficacy and social self-efficacy were unique mediators in the relationships between parental involvement (both paternal involvement and maternal involvement) and adolescent positive affect. Furthermore, academic self-efficacy was found to be the only unique mediator in the relationships between parental involvement and adolescent life satisfaction. Emotional self-efficacy did not uniquely mediate the relationships between parental involvement and adolescent positive effect and life satisfaction. The proposed mediators of the study did not uniquely mediate the relationships between parental involvement and adolescent negative effect. Paternal involvement is just as crucial to adolescent positive development as maternal involvement. In addition, this study also extends into the specific roles of academic, social, and emotional self-efficacy in the relationship between parental involvement and the components of subjective well-being among adolescents (Yap & Baharudin, 2016).

The Significance of the Attachment Theory

Attachment theory is a fit for my research study as it relates to depression mothers because it focuses on the parent-child relationship and personality disorders consisting of inflexible patterns (Lyddon & Sherry, 2001). According to Barker (2004), this theory focuses on children's social attachment with their caregivers and their personality

characteristics through adulthood. The attachment behavior system is an important component of the attachment theory.

Attachment theory is applied to this research study as it relates to depressed mothers because it focuses on the outcome of the mother's efforts to become accustomed to her required growth and her changing environment, both of which are concerned with meeting the needs of the child (Ecker & Hulley, 1996). According to Holmes (2012), attachment theory contributes to aiding practitioners who specialize in adult psychotherapy. The attachment theory was developed from psychoanalysis, the cognitive-development psychology theory and the control systems theory (Obegi & Berant, 2010). According to Barker (2004), psychoanalysis is a method for treating and diagnosing mental illnesses and gaining a better awareness of self while using the principles of the original psychoanalytic theory, which was developed by Freud. Waters, Crowell, Elliott, Corcoran, and Trebox (2002) found that attachment theory helps to determine whether the child who suffers from attachment issues is likely to suffer as an adult. Smeekens, Riksen-Walraven, and van Bakel (2007) found that, based on attachment theory, early signs of detachment cause an increased risk of a child's externalizing problems. Attachment theory shows how parenting mothers affect their child's positive and negative interactions (Marotta, 2002). Morris et al. (2002) found that children who have resilience develop a sense of stable emotion and internalize less negativity.

John Bowlby (February 26, 1907- September 2, 1990) was a psychologist and psychoanalyst who believed that early childhood attachments played a critical role in

later developmental and mental functioning. Bowlby's attachment theory suggests that children are born pre-programmed to form attachments with others, because this will help them survive. He believed babies are born with social releaser behaviours such as crying, babbling, cooing, and following that stimulate caregiving from adults because adults are biologically programmed to respond to infant's signals. Bowlby believed it was natural to need other people throughout the life span. In clinical Psychology, people who need others could have a Dependent Personality Disorder.

History of Depression

To understand how depressed mothers' relationships with their children may be affected by their pathological symptoms, a history of depression is needed to provide context. According to Eastman (2011), approximately 22% of people or over forty million Americans, suffer from a type of depression every year. Depression is a mood disorder that negatively impacts one's ability to think clearly. It frequently changes the individuals sleeping and eating habits (Segal, Williams, & Teasdale, 2013). Garber, Ciesla, McCauley and Diamond (2011) found that depression is considered "the common cold" of mental illness in adults and causes problems for families as it relates to the child parent-child relationship and an increase in the use of medical and mental health services. A study that examined whether the mother's depression was the cause of their children's symptoms of depression and functioning included 223 mothers who were parenting children ages 7-17 (Garber, Ciesla, McCauley & Diamond, 2011). The sample included 126 mothers who were in treatment for depression and 97 who were not in treatment. The parent's level of symptoms, such as rejection, hostility, withdrawal, and over-control

during the observation, determined the severity of the effects of the depression. Changes in the parent's depression resulted in changes in children's symptoms (i.e., when a parent's symptoms are remitted (go into remission) the child's symptoms improve (Garber, McCauley, Ciesla, & Scholredt, 2011). According to the Medical Dictionary (2012), when one is in a remitted condition, he or she is in remission which means the symptoms are no longer in effect.

Doctor John Cade (January 18, 1912 – November 16, 1980) was an Australian psychiatrist who first identified depression (Australian Dictionary of Biography, 1993). When he was six years old, his father left to fight in World War I. When he returned, he was no longer able to work as a physician due to "war weariness," an effect of his war experience. War weariness is defined as a negative effect of war that causes one to feel excessively tired (Australian Dictionary of Biography, 1993).

According to the Australian Dictionary of Biography (1993), Cade attended Scotch College, Melbourne in 1928. He then studied medicine at University of Melbourne. After graduating, Cade became a house officer at St. Vincent Hospital and the Royal Children's Hospital prior to becoming ill. A house officer is responsible for diagnosing and administering general medical services to clients. In the book *Mending the Mind* (1979), Cade described depression as "the most painful illness known to man, equaling or exceeding even the most exquisite physical agony. The patient is inconsolably despairing, often completely immersed in the internal world of misery and utter loneliness (Cade, 1979). He also believed that there is no pleasure in living, any energy or interest in doing anything except agitatedly bewail or silently brood upon an

unhappy fate; no hope for the future, abandoned by God and man (Cade, 1979). Cade did not have any specific name for depression; however, he experimented to determine how to treat the illness. Cade believed that depression was caused by strong despair.

Initially, depression was called melancholia in ancient Mesopotamian texts in the second millennium B.C. (Nemade, Staatts-Reisss, & Dombeck, 2007). At this time, all mental illnesses were attributed to demonic possession, and were attended to by priests. In contrast, a separate class of "physicians" treated physical injuries (but not conditions like depression). The first historical understanding of depression was that depression was a spiritual (or mental) illness rather than a physical one. Ancient Greeks and Romans were divided in their thinking about the causes of melancholia. Literature of the time was filled with references to mental illness caused by spirits or demons.

The term *depression* comes from Latin verb, *"deprimere"* which means *pressing down*. According to Mitchell and Hadzi (2000), Cade described symptoms of depression as the experience of fear and despondency. While treating patients with those symptoms, Cade used the drug Lithium experimentally, to gauge its results. Urine from patients was injected into the abdomen of guinea pigs to help determine the effect on patients prior to adding Lithium as part of the solution. As Cade used careful controls, such as increasing water solubility and adding Lithium urate, he recognized that Lithium was a necessary treatment for patients suffering from both depression and mania (Mitchell & Hadzi, 2000).

The understanding of depression as a disorder has improved gradually over the years (Robbins, 2009). According to Shorter (2013), within the last forty years,

depression as a diagnosis has increased and is managed with more than one type of treatment according to the severity of the depression. Modern day discoveries related to depression are significantly advanced since the early years. Current treatments for depression include both prescribing an antidepressant and repairing the damage caused by the depression (Carver, 2013). According to Carver (2013), the damage caused by the depression is determined by two situations: sudden, severe loss and long-term high stress levels. With sudden severe loss, the patient experiences a surprising severe loss such as a death of a loved one, loss of a job, loss of a friendship, or other process of grief. When long-term, high stress levels cause depression, the patient is depressed, but does not know the cause of it. Common antidepressants are Prozac, Zoloft and Paxil, which are selective serotonin reuptake inhibitors (SSRI's) (Carver, 2013). Both situations do not use the same antidepressants because the severity of the depression varies (e.g. mild, moderate, severe).

During the 20th century there were several psychiatrists who contributed to the body of knowledge about the treatment of depression. Roland Kuhn (March 4, 1912 - October 10, 2005), was a Swiss psychiatrist, that dispensed the first antidepressant, Imipramine, in 1956 to Paula JF for her "vital depression," also known as major depression. Paula became delusional on the third day of treatment. She exhibited manic and "fidgety" behavior. Seven days later, Paula began to recover. When Kuhn completed Paula's treatment, and after working with other psychiatrists, he considered Imipramine to be a success. Imipramine and Iproniazid were two commonly used medications used to treat mood disorders (Lopez-Munzo, Alano, Juavis & Assion, 2007). In the early 20th

century, choral hydrate, barbiturates, amphetamines, and opiate derivatives were used to treat agitation in melancholic patients. Throughout the first half of the 20th century, biological treatments that were used included insulin coma, chemical, electric shock therapy, and sleep cures.

Max Lurie and Harry Salzer were the psychiatrists who worked in outpatient private practice treating depressed patients during the 1950's (Lurie, 1998). In 1952, Lurie was first to use the term "antidepressant" (Lurie, 1998). Lurie and Salzer jointly developed Chlorpromazine (Weismann, 2008). Although Imipramine was the first antidepressant used, Chlorpromazine was considered the leading antidepressant next to Imipramine during the 20th century (Kuhn, 1996). They also began to treat depressed patients with Isoniazid based on clinical observations by Jackson Smith who used it to treat his tuberculosis patients. He suggested that it would help treat depressed patients efficiently because his TB patients developed better appetites, which resulted in weight gain and better sleep habits (Lurie, 1998).

In 1959, Eric West and Peter J. Dally identified atypical depression. William Sargant took their research to the next level (Sargant, 1961). William Walters Sargant (April 24, 1907 – August 27, 1988), a British psychiatrist specialized in psychosurgery, deep sleep treatment, electroconvulsive therapy, and insulin shock therapy. Sargant received his training in medicine at St. John's College, in Cambridge, and became a qualified doctor at St. Mary's Hospital in London until he retired in 1972. Sargant's desire to become a physician was derailed by a mental health episode of his own – a nervous breakdown, after which he became interested in studying psychiatry with a

specialty in brainwashing (Beard, 2009). Brainwashing is a psychiatry specialization that pertains to the teachings of thought control. Thought control is a non-scientific concept that the human mind attempts to restrict ideas and impose opinions through censorship to be controlled by certain psychological techniques (Sargant, 1957).

In 1968, MAO-B was discovered in the brains of rats by Johnston, at the Research Laboratory of May and Baker Ltd. in Dagenha, UK (Johnston, 1968). The treatment of depression has changed greatly since the 20th century. There are various types of antidepressants, patient use and response, which have not been influenced by one particular outcome (Cronkite & Moos, 1995; Thase & Glick, 1995). Yapko (2013) found that psychotherapy is often used to treat depression, but has advantages and disadvantages. The advantages of using psychotherapy are building of skills, reducing client relapse, a healthy therapist-client relationship, and motivating the client during the process of change that takes place during therapy. The disadvantages are, the client relies too much on the clinician's expertise and judgments, and the client's sensitivity if the clinician presents information that is difficult to hear (Mondimore, 1993; Thase & Howland, 1995). According to Aneshensel (2012), when clinicians explain to the client what the treatment is and why it is needed, the client is more likely to receive needed treatment. Schwartz (1996) found that using psychotherapy is as effective in treating depression as using medication only.

In the 1970's more research was completed, focusing on new antidepressants on the market, Monoamine Oxidase Inhibitor MAO and Monoamine Oxidase-A. Monoamine Oxidase Inhibitor (MAO) are chemicals that reduce the activity of certain

enzymes. Both MAO and MAO-A are found naturally in the intestinal lining and high levels are associated with depressive disorders. Monoamine oxidase-A (MAO-A) degrades the body's naturally occurring neurotransmitters such as, dopamine, norepinephrine, and serotonin. When the MAO inhibitors reduce the body's production of MAO-A, these beneficial neurotransmitters are able to help patients in cases of intolerance to medication, lack of therapeutic response to antidepressants, incontrollable depression, or when electroconvulsive therapy is rejected or impractical (Ban, 2001, &Yost, 1948). Furthermore, when depression is treated early, this improves the mother and child relationship and leads to better parenting.

The Impact of Depression on Mothers

Mothers who suffer from depression usually develop negative effects relative to their health and growth (Bonari, et al. 2004). Pinheiro, Magalhaes, Horta, Pinheiro, da Silva and Pinto (2006) found in their study that maternal depression causes increased health risks such as gastrointestinal illness and poor physical development. The psychological distress of depression has an impact on society because it affects children and causes social dysfunction (Elgar, 2003). Some symptoms are internalized through withdrawal, anxiety, and somatic discomforts. Other symptoms are externalized as behavioral excesses, such breaking rules and exhibiting aggressive behaviors (Wilmshurst, 2013). Parenting mothers who experience recurring depression, are usually experiencing stressors such as inadequacy in their finances and lack of positive relationships (National Research Council and Institute of Medicine, 2009). O'Hara and

Swain (1996) found that depression and symptoms of depression are both common in populations that are considered disadvantaged. Their research indicated that in households that are below the federal poverty threshold, 1 out of 4 parenting mothers of infants experience moderate to severe levels of depressive symptoms.

Stressors in the mothers' environment are associated with depressive symptoms. Depression frequently coexists with some risk factors, such as race and poverty. The Los Angeles County Women, Infants and Children (WIC) survey administered by First 5 LA (2005) was used to screen for depressive symptoms. Research recipients were part of the WIC population. The percentages of symptoms vary among racial-ethnic groups such as Latina English-speaking (14.7%), African Americans (15.8%), Caucasian (16.8%), and Latina Spanish-speaking (22.7%).

Mental health services for the low-income population are very limited (Mian, 2005). Mothers who are considered distressed and violent toward themselves and/or their children need to receive treatment from mental health service systems. As stated earlier, depression left untreated can affect children and entire communities. The top environmental stressor of mothers in L.A. County was financial and housing instability. Seventy-two percent of low-income families in L.A. County report extreme difficulty paying for housing (Mian, 2005). Curtis, Corman, Noonan, and Reichman (2014) found that maternal mental illness places families with young children at risk for homelessness. Unfortunately, there is limited literature on the links between mental illness and homelessness.

Mauthner, Stoppard & McMullen (2003) found that maternal depression can stem from a life transition. According to the Association for Advanced Training (2012), life transitions are developmental changes that cause changes in one's status or role and come from a loss and/or other crisis. Becoming a new mother and getting divorced are examples of life transitions (Zastrow and Kirst-Ashman 2004). Furthermore, a life transition is causes disruption in family routines, stressful home environments and the inability to parent effectively (Marmorstein, Malone & Iacono, 2004). The purpose of this study was to explore whether major depression along with antisocial behavior occur among partners of mothers experiencing depression versus mothers who are not suffering from depression. The participants in this study were from the Minnesota Twin Family Study, which is a community-based study of twins and parents. Both the biological fathers of the twins along with their 17-year-old children participated. Researchers assessed participants for major depression, conduct disorder, and adult antisocial behavior. The results indicated that depressed mothers usually were partnered by antisocial fathers. Results also included, that depression among mothers where there is antisocial behavior in biological fathers were both significant and independently related to depression and conduct disorder among their biological children. The gender of the twins was not determined to relate to parental diagnosis as the study was not based on gender of the twins (Marmorstein, Malone & Iacono, 2004).

Along similar lines of research, Tulman and Fawcett (2003) completed a quantitative study on depressed mothers. They found that the mothers usually feel dissatisfied with a sense of physical and psychosocial ill-health, which affects their social

functioning and relationships among family members, and is linked to the severity of the depression. According to Huang and Freed (2006), mothers suffering from depression experienced an inability to sleep and eat, and were unable to enjoy being a mother, because of behavioral responses to depression.

These studies on maternal depression showed that personal relationships often suffer. Thus, depressed mothers who are at an increased risk of developing less trustworthy relationships, and may lack social support (Edge & Rogers, 2005). According to Gullotta and Blau (2008), maternal depression increases depression symptoms in children because of biological, not just environmental factors. According to Cummings and Davies (1994), biological factors increase the risk of depression in children.

Lastly, Jacob and Johnson (1997) found that depression could affect the relationship between the mother and child. The purpose of this study was to determine the difference between maternal depression and paternal depression and how it impacts their children. Participants of this study were recruited in Pittsburgh, Pennsylvania via a newspaper advertisement, which specified a study of alcoholic and depressed families. The participation requirements were parenting children ages 10 –18 years old. In this quantitative study they found that mothers who are depressed tend to seem negative and appear to interact less with their children. All participants in this study completed intensive three-week assessments, including laboratory interviews, interaction tasks, questionnaires, and home observations. The test used to complete this study was the one-way analyses of variance (ANOVA). Prior to conducting MANOVA, the researchers completed a number of preliminary analyses to confirm statistical hypotheses. The three

groups studied were, 1) parents without depression (control), 2) fathers with depression, and 3) mothers with depression. Participants were grouped according to number of years married, paternal age, paternal education, mean of paternal and maternal Differential Ability Scales, paternal IQ, maternal IQ, paternal socioeconomic status (SES). The negative effects of maternal depression suggested a need for further research to attain a better knowledge and analysis of the mother and child relative to child outcomes as influenced by both their father's and mother's depression. In previous findings, paternal depression seems to result in less impairment in the parent-child relationship and less disturbance in children as than depression among parenting mothers.

In another study, research participants were assessed using a psychosocial functioning assessment which included 1) a Child Behavior Checklist, 2) Beck Depression Inventory (BDI), and 3) The Minnesota Multiphasic Personality Inventory Scale II (MMPI). The Child Behavior Checklist includes 32-items with high internal consistency. It is used to distinguish scores among parents, other close relatives, and/or guardians who are distressed. In this study, there was a correlation between both parents. Differential Ability Scales (DAS) were used to determine the correlation between scores. Those scores help to distinguish the significance of the results. Scores indicated as expected that families with a depressed parent exhibited decreased positivity and congeniality compared with families without a depressed parent; parental depression and affect expression were clearly linked within the family matrix.

Mothers and Depression and How It Impacts the Children

Cummings and Kouros, (2009) found that maternal depression is a cause of ineffective parenting skills. Extensive research documents links between marital conflict and child maladjustment in families with maternal depression. In contexts of maternal depression, marital conflicts are characterized by lower positive verbal behavior, sad affect, increased use of destructive conflict tactics, and lower likelihood of conflict resolution. Studies are explicitly testing family processes, including interparental conflict, as mediators or moderators between maternal depression and children's outcomes. The findings show that maternal depression is related to increased interparental conflict and relationship insecurity, more family-level conflict and overall family functioning. Disruptions in these family processes, in turn, are related to higher levels of children's psychological distress and adjustment problems.

Lovejoy, Graczyk, O'Hare, and Neuman (2000) found that when a mother-child relationship seems inadequate or is inadequate, it is often because of the mother's mental health. The researchers completed an observational study with a symptom-based approach on a group containing a high percentage of mothers who displayed inadequate parenting and a smaller percentage of mothers who displayed less child disengagement. A statistical analysis of 46 observational studies was completed. The researchers studied to the strength of the association between maternal depression and parenting behavior and sought to identify variables that moderated the effects. The studies were reviewed to determine whether the mother's depression was the influential components in the negative maternal behaviors and to identify the effects of moderated variables. The

purpose of this study was to determine the parenting difficulties of mothers diagnosed with depression. Researchers rated the mother's response to her child as negative, disengaged, or positive. Between all disengaged maternal behavior and negative maternal behavior, there was a correlation that ranged from -.12 to .50. From the 20 effects related to maternal disengagement, 9, or 45%, significantly differs from zero which equal to $p<.05$ and in the direction expected; effect sizes, which was 11, or 55% did not differ from zero (Lovejoy et al., 2000). These statistics reflect correlation between disengaged maternal behavior and negative behavior, and show that

both maternal behaviors result in a high occurrence of symptoms in children that must be reduced or alleviated.

Maternal depression disproportionately affects mothers who receive inadequate income according to prevalent research data (Knitzer, Theberg, & Johnson, 2008). According to Sheffield (2000), mothers who are depressed may become depressed because of the number of children they have. Maternal depression affects children's development and, causes their adverse behavior (Goodman, 2007). Furthermore, Knitzer, Theberg, and Johnson (2008) also posited that the children in the sample exhibited behaviors such as lack of school readiness and a healthy start. Therefore, the National Center for Children in Poverty (2008) found that having a healthy start improves child development and school readiness.

The risk of biologically linked depression in a family increases when there is poor adjustment to parenting, which in turn affects the mother's mood that causes aggravation and stress and exacerbates depression in both mother and child (Goodmand & Gotlib,

1999). Prior depressive episodes in mothers may result from inadequate income, single parenting, marriage difficulties, or lack of social support. These factors seem to impact the mother negatively, causing her to feel overwhelmed and/or disengaged (Goodmand & Gotlib, 1999). According to Geist (2004), prior depression puts women at risk for maternal depression.

Turley (2003) identified the impact of depression on healthy family relationships and found that it makes it difficult to maintain them. A quantitative study was done on maternal depression that documented a negative impact on the social development of children (Solantaus, Paavonen, Toikka & Punamaki, 2010). Solantaus et.al (2010), concern as a researcher of this study is the transfer of mental illness from generation to generation and our interest is to learn how to contribute to breaking the cycle in daily clinical practice in the health system. The increase of maternal depression is linked to a higher incidence of anxiety and other psychiatric disorders in children.

Interventions That Addressed Family Life and Social Adjustment of Children

The Solantaus et al. (2010) study focused on the consequences to family life and on the social adjustment of children as it relates to mental health in childhood and adulthood. The researchers studied patients with mood disorders in two sample groups. One group contained mothers and fathers and one-group fathers only. The study included 119 families initially, but only 109 completed interventions and baseline evaluation. All the families who completed the study had been diagnosed with depression. They found that providing support for preventive mental health measures for mentally ill parents is effective. Two specific preventive tools were used with families. The Family Talk

Intervention (FTI) and Let's Talk about the Children (LT). The Family Talk Intervention (FTI) seemed to work better than the Let's Talk about the Children (LT) relative to the measurable emotional symptoms in the depressed parents. Effectiveness was determined by using both instruments. Using those instruments did not only prevent the increase in symptoms among children, but it decreased the symptoms in both groups. Instruments are used to measure to determine whether the instrument measures what it is supposed to measure (Rubin & Babbie, 2008).

According to Solantus, Paavonen, Toikka, and Punamaki (2010), the Family Talk Intervention (FTI) includes two parental sessions where personal and family intervention is discussed. The mental health clinician also meets with the child to determine his or her psychosocial situation and family experiences. The mental health clinician and parent also discuss the parent's mental status. Prior to the FTI, a planning session takes place. The mental health clinician educates the parent about how to effectively respond to his or her children's questions and how to intervene when family problems occur (Podorefsky, McDonald-Dowdell, & Beardslee, 2001).

The intervention called Let's Talk About the Children (LT) has worked effectively with depressed parents outside the United States. This intervention is a brief psycho-educational discussion that occurs between the clinician and a parent who has consented to participate. The purpose is to determine the effectiveness of a preventive family intervention as it relates to the child's psychosocial symptoms and the parent's pro-social behaviors (Solantaus, Paavonen, Toikka, & Punamaki, 2010). This intervention provides professionals with the information necessary to determine the

severity of the parent's mood disorder. Both the FTI and LT are effective because these interventions prevent an increase in children's symptoms. In both interventions, the child's pro-social behavior improved and emotional symptoms, such as anxiety, and hyperactivity decreased. The FTI was highly effective with reducing emotional symptoms it relates to the LT. The dependence of time was the high effect of using the FTI. The intervention of both groups was similar in their baseline demographic factors, except for LT showed, mothers' have lower education and marginally the larger number of divorced/separated families.

Sixty-seven mothers had been diagnosed with unipolar depression (33 in the LT, 34 in the FTI); eight with of bipolar disorder (5 in the LT, 3 in the FTI), and four had a diagnosis of anxiety disorder with depression (2 in the LT, 2 in the FTI). There were no significant differences between the two intervention groups in terms of diagnoses. According to Solantaus, Paavonen, Toikka, and Punamaki (2010), the impact of the interventions was assessed by interviewing two parents about personal and family history and using psychoeducation about depression and resilience. Following the two-parent interview, a child session occurred during which each child is interviewed about its family experiences and possible concerns or questions related to parental mental illness. Sixteen health care units in eight regional and national health organizations located in different parts of the county participated in the study (Solantaus, Paavonen, Toikka, and Punamaki, 2010).

Kelley and Jennings (2003) found that a decrease in positive interaction between the mother and the child resulted in a negative response, such as maternal withdrawal.

The purpose of this quantitative study was to explore the influence of maternal depression on the development of helplessness in toddlers. The Structured Clinical Interview for DSM IV was administered to mothers with depression in their home. One hundred thirty-four mothers including their toddlers participated in this study. The assessment visit during the initial 18 months reported 71 out of 111 mothers were found to be clinically depressed. Participating mothers were ages 20 – 46 with a mean age of 33.7. Thirty-three participating mothers were found to have never become clinically depressed. Five mothers were recruited as non-depressed, but met criteria for inclusion in the depressed group, and a friend referred one mother. The non-depressed mothers were recruited through a large obstetrics hospital, and one control mother responded to the posters describing the study. Results were determined by categorizing those mothers by socio-economic status, race, whether a father is in the home, equivalency of roles, and gender of the child. The children who were included in this study were 18, 25 and 32 months old. Investigators from the University of Pittsburgh visited mothers of 18-month old toddlers as part of their study. They found that mothers diagnosed with "double depression" reported significantly more depressive symptoms than other depressed mothers (with only one depression type) at the 18-month mark. According to the American Psychiatric Association (2013), double depression is an expression used to define a condition in individuals who experience long-term mild-to-moderate depression (dysthymia) and began having episodes of major depression. The study found that the effects of consistent exposure to depressive symptoms in the mother is more significant to children than either early exposure or the type of depression experienced by their

mothers. The two follow-up research studies by Kelley and Jennings (2003) suggested further research is needed, because depression is considered to have a helplessness effect in many mothers.

Diagnosis of Depression in *DSM-5*

The American Psychiatric Association (APA, 2013) developed the Diagnostic and Statistical Manual of Mental Disorders, which provides thorough information as it is about the various mental disorders. According to the *DSM-5*, symptoms differ according to the type of depression and the age of the depressed individual (*DSM-5*, 2013). *DSM-5* (2013) delineates mild, moderate, and severe depression. Mild depression includes symptoms that can be repressed by sensory stimulus or distraction. Mild symptoms can be distressing, but manageable and result in only minor impairment in social or occupational functioning. Moderate depression includes symptoms that require explicitly protective measures and behavioral modifications. Moderate symptoms fall between those specified for "mild" and "severe." Symptoms are considered moderate that are less long-term than severe symptoms. Severe depression includes symptoms that are considered long-term or chronic. Severe symptoms are seriously distressing and unmanageable, and markedly interfere with social and occupational functioning. Long-term means at least two years. As mentioned earlier, double depression refers to long-term mild-to-moderate depression (dysthymia) with intermittent episodes of major depression (American Psychiatric Association, 2013).

According to Nonacs (2006), the symptoms and characteristics of depression are both psychological and physical. The psychological symptoms of depression are sadness,

tearfulness with withdrawal from interests, pessimistic attitude, hopelessness, lack of confidence, suicidal thoughts and can include anger and tension. The physical symptoms of depression are fatigue or lack of energy, physical tension, sleep disturbance or insomnia, loss of libido, problems associated with memory and pain (i.e., headaches, back pain, and upset stomach).

Maternal Depression

Like most of the studies cited in this chapter, Sheffield (2001) also found that depression causes impairment in a mother's daily routines and functioning, which leads to ineffective parenting and can cause long-term negative impacts on the children (Goodman & Golib, 1999). According to Cummings and Davies (1994), risk factors for depressed mothers, include instability within the family, incarceration in adulthood and negative internalizing and externalizing behaviors. According to Benson & Haith (2009), parenting skills affect the development of children. The mother-child relationship and parenting skills of depressed mothers are the primary focus of this study.

Maternal depression is a social problem that needs to be researched in order to provide professionals with the information and knowledge to enhance the social functioning of mothers and their parenting skills. Many mothers need to know the causes, symptoms, and the impact of depression on their parenting, because this promotes awareness, which also promotes prevention and intervention. The purpose of this study was to explore how mothers who have experienced depression with peripartum onset, perceive their social support systems as an influence on their self-efficacy to parent.

Wan & Green (2009) found that depression among parenting mothers is considered difficult to study because it is difficult to determine whether the mother-child relationship is negatively affected by the mothers' detachment alone. According to Wan and Green (2009), researchers who have studied maternal depression and its impact on parenting skills found that the Beck Depression Inventory (BDI) was a beneficial instrument to use to measure the depression in mothers, because it shows clear links between maternal symptoms and behavior problems. The Beck Depression Inventory is the most commonly administered self-report measure to assess levels of depression (Thyer & Wodarki, 2007). One meta-analysis study focused on insecure attachment in 15 studies (N=953). The results showed a significant maternal depression outcome (r=0.18; Atkinson, Paglia, Coolbear, Niccols, Parker, & Guger, 2000). Samples that were larger that included adolescents produced a smaller size, differed from Martin's and Gaffan's (2000) rationale and no moderating effect. The rationale of the literature for the variables or concepts, which are the cause and effect are included in this research study. This inclusion is necessary because both types of variables help to explain the hypothesis and how the research questions fit this quantitative study.

According to Lovejoy et al. (2000), earlier studies have been inconclusive regarding findings related to maternal depression. Earlier studies were inconclusive because depressed mothers reported diminished emotional involvement, impaired communication, disaffection, and increased hostility and resentment (Weissman, et. al 1972). Furthermore, Goodman and Brumley (1990) found that the strong association between depression and self-reported parenting problems offered one explanation for the

adjustment difficulties experienced by children of depressed parents and provided the impetus for subsequent observational studies that objectively assessed the quantity and quality of parent-child interactions in families with a depressed mother.

Foster, Garber, and Durlak (2008) found that adolescents may increase challenges for mothers, which demand modifications to their daily routines, the capacity to negotiate those modifiers are not determined in the present research. Weissman and Paykel (1974) found that mothers who experience marital conflict and difficulties interpersonally are at increased risk of depression. Depression in mothers continuing up to four years post episodes increases impairment in relationships (Rounsaville, Prusoff, & Weissman, 1980).

In the last few decades, children and adolescents living with a depressed parent or guardian have been at increased risk for a wide range of emotional and behavioral problems during the preschool, middle childhood, and adolescent years (Colletti, Forehand, Garai, Rakow, McKee, Fear & Compass, 2009). Substantial research suggests that parental depression is associated both offspring internalizing and externalizing problems (Elgar et al. 2007). However, parental depression appears to have non-specific associations across these two types of child problems, and with disorders from within each of these broadband categories.

According to Goodman and Tully 2006; Shanahan et al. 2008, investigators (McKee et al. 2008; McMahon et al. 2003; Shanahan et al. 2008) have emphasized the importance of examining whether particular risk factors, such as parental depression, are associated with specific child outcomes. Downey and Coyne (1990) found that the

children of mothers who are depressed are exposed to negative family environments, which put them at high-risk, as evidence of deficiencies in their social and achievement. The purpose of this study was to review the various literatures on the adjustment of children of depressed parents, difficulties in parenting and parent-child interaction in these families, contextual factors that may play a role in child adjustment and parent depression. Women who self-report that they are suffering from depression, but whose symptoms are found to be equivocal during clinical interviews are often found to have mild and transient depression (Coyne and Gotlib, 1983). Many studies have investigated the relation between parental depression and a wide range of child outcomes. This review focused on three sets of outcomes: 1) measures of psychological functioning, 2) clinical disorders, and 3) potential markers of vulnerability to depression. Studies of children of depressed parents today are controlled and use control groups that confirm the assessment. The conclusions that children of depressed parents show heightened rates of general problems in adjustment, putative markers of risk for depression and clinical depression, help researchers focus future study. Learning about schizophrenia before attempting to undertake long-term longitudinal studies of children of depressed parents is likely to answer more questions. Obtaining the necessary answers to questions about the nature of depression in children of depressed parents will include examining biological suffering from high levels of stress and distress from which their parenting difficulties stemmed. Downey & Coyne (1990) has not yet determined implications for the disorders that emerge in children of depressed parents in later childhood or adolescence.

According to Brummelte (2016), pregnancy and postpartum depression are associated with an increased risk for developing ongoing depressive symptoms in women. Maternal depression may result in inadequate parenting skills and consequently may have a negative impact on children (Burke, 2003). Brummelte (2016) found that maternal attachment, sensitivity, and a positive parenting style are essential for the healthy maturation of an infant's social, cognitive and behavioral skills. Depressed mothers often display less attachment and sensitivity, and more harsh or disrupted parenting behaviors, which may contribute to adverse outcomes in children of depressed mothers. Barker (2004) found that depression is an emotional reaction that includes feelings of sadness, discouragement, despair, and pessimism about the future. It reduces activity and productivity. This disease may also cause disturbances in sleep, excessive fatigue or feelings of inadequacy and hopelessness (Barker, 2004). These feelings vary by individual and in severity. Earls (2010) found that children of mothers who suffer from depression are more likely to have difficult temperaments, difficulty reading cues, and a lack of stress management skills, and a tendency to be insecurely attached. They suffer chronic health conditions and are more likely to have experienced birth trauma.

The Impact of Maternal Depression on Children

Maternal depression and its effects on children have been a research focus from various perspectives. For example, Radke-Yarrow and Klimes-Dougan (2002) found that school age children of depressed mothers usually have less parental experience. When children lack understanding and coping mechanisms, they are unable to self-help or maintain a do-it-myself attitude or skills, which allow them to cope with normal stressors

outside the home. The genetic component has been studied as well to determine how nature vs. nurture influences the children of depressed parents. The 2002 study shows that problems among children stem from factors such as 1) characteristics of the parent's illness, (amount and severity of behavioral impairment), 2) conditions and relationships in families with a depressed parent, and 3) parenting behavior of the depressed parent. These factors show significant associations between parent variables and offspring functioning (Radke-Yarrow & Klimes-Dougan, 2002). According to Naylor (2009), children who experience depression may appear to be experiencing mood swings, which is typical for school age children, and thus are not necessarily identified as a mental health disorder.

Mother-Child Relationship

According to Kendall-Tackett (2009), children may suffer from negative physical outcomes, dependent upon the child's age and the presence of maternal depression. Maternal depression is not good for the mother nor the child because it leads to increased risk of cardiovascular diseases, a suppressed immune system, and a decrease in positive health behaviors (Kendall-Tackett, 2009). Rettew (2013) found that the child's temperament can be negatively affected throughout adulthood if he or she receives inadequate attention from the mother, as well as other family members, teachers, and peers.

Research studies on maternal depression and children in this age group show that 10 – 20% of parenting mothers will become depressed at some time in their lives (Kessler, Berglund, Demler, Jin, Koretz, Merikangas, Rush, Walters, & Wang, 2003).

Furthermore, Mian (2005) found that 1 in 11 infants feel a mother's chronic depression during their first year of life because of the significance of the depression.

In the child's early years, ages 2 – 6, attachment between the mother and child emerge as the child develops during their first year of life (Klimes-Dougan, & Kopp, 1999). McMahon, Barnett, Kowalenko and Tennant (2001) found that the attachment style of the mother has an impact on her child's temperament. Poor attachment results in anxiety during the development of the child. Shur-Fen and Pei-Chen Chang (2013) found that impairment in the maternal attachment process could occur because of the mother's depression, lack of treatment, and lack of knowledge of comorbidity.

In the school age years, specifically ages 7–11, attachment between the mother and child is also vital. Often, when an assessment is needed to determine the attachment between the mother and pre-adolescent, the Child Attachment Interview (CAI) is administered to children ages 7–11. These interviews are scored based on verbal and non-verbal communications (Schaefer & Digeronimo, 2000).

In the adolescent years, ages 12–18, a lack of parental interaction causes depression in the adolescent (Angold & Costello, 2001). Closeness between the mother and adolescent results in good communication and positive investment in the child by the mother (Takahashi, 1993).

In their study Gau and Chang (2013), investigated the mother-adolescent relationship when the adolescent is who diagnosed with ADHD, comparing the study group with adolescents who were no diagnosed with ADHD. Using DSM-IV for diagnosing purposes the study included 190 students with ADHD, 147 students with

ADHD, and 223 students without ADHD. The mothers and the children who participated in the study were interviewed by psychiatrists to determine their diagnosis. The Parental Bonding Instrument was used to assess the mother's parenting level and the Social Adjustment Inventory for Children and Adolescents was used to determine the adolescents' relationships with their mothers and any possible behavioral issues in the home. Attention Deficit Hyperactivity Disorder (ADHD) relate to depression.

Parenting Styles

Diana Baumrind (August 23, 1927 – September 13, 2018) identified three parenting styles explained in the following paragraphs. Her study pertained to how parents responded to their children's needs. Baumrind was a developmental psychologist whose dissertation was titled "Some personality and situational determinants of behavior in a discussion group" (Kemp, 2013, *Division 35*). When Baumrind graduated with her Ph.D. she worked as a staff psychologist in Berkeley at Cowell Memorial Hospital. She also became a director of two United States Public Health Service projects and worked as a consultant on the state of California project, and had a private practice (Kemp, 2013).

The three parenting styles Baumrind identified are as follows: 1) Insecure-resistant/permissive: Parent(s) with this style do not seem directive and provide less discipline to control their children (Zastrow and Kirst-Ashman, 2004) 2) Insecure-avoidant/authoritarian: This term applies to parents who use punishment frequently to halt the undesired behavior(s) of their children (Barker, 2004) 3) Secure/authoritative: Parent(s) with this style usually possess neither an authoritarian nor a permissive character. They seem to have control over their child because they have definite

communication strategies and their expectations are much higher. For examples, the child is expected to act with appropriate maturity (Zastrow and Kirst-Ashman, 2004).

These three styles of parenting relate to the current study. Parenting styles vary among parents; however, many depressed mothers are considered to be insecure-resistant/permissive, which may be linked to the impairment of the mother-child relationship and thus influence the child's mental health (Pappas, 2011). These links were determined by assessing mothers who suffered from depression including their parenting skills and determining whether their parenting skills were the influential matter in the mother-child relationship. Many depressed mothers are not insecure-resistant/permissive, but do meet some other parenting style criteria. The connection between parenting styles and maternal depression is an important issue to understand in this study. Mothers who are depressed tend to discipline their children less and seem less assertive (Newman & Newman, 2003). Furthermore, Newman and Newman (2003) found that depression is an emotional state of sadness that is influenced by low self-esteem and disengagement from others. According to a current report from the National Academy of Sciences (2013), depressed mother's parenting skills are affected by their mental status and an altered mental status causes impairment in the caregiving or nurturing they provide. Those mothers tend to have a less positive relationship with their child, which may cause negative interactions (Zastrow and Kirst-Ashman, 2004). Participating mothers older than 18 years who are parenting child(ren) younger than 12 years were interviewed concerning their experience with peripartum onset depression. About 7-10 interview questions were used to explore the mothers' experiences.

Types of Parenting Style

Understanding parenting styles is critical to framing this research problem of recognizing the significance of depressed mothers' relationship with their child(ren) as it relates to parenting. Parenting styles is not a theory; however, it is a psychological construct representing standard strategies that parents use in rearing their child(ren). According to Paulson (1994), psychological constructs are typological categories of Baumrind's parenting styles, such as authoritative and authoritarian. Diana Baumrind's uninvolved parenting theory provides insight on how parents interact with their children (Sigelman & Rider, 2014). Baumrind (1966) presented two parenting actions, parental responsiveness and parental demandingness. Parental responsiveness refers to how the child's needs are met by the parent. Parental demandingness pertains to the times the parent expects mature and responsible behavior from the child. While researching those two concepts Baumrind discovered three styles of parenting. The three styles of parenting were: 1) authoritarian, 2) permissive and 3) authoritative. Each of those parenting styles is different. For example, the authoritarian parent is considered too harsh or demanding, the permissive parent is passive or too soft, and the authoritative parent is reasonable utilizing just the right amount of the discipline. Lastly, Baumrind (1967) discovered one more parenting style: negligence. That particular parenting style reflects an uninvolved parent who focuses primarily on the self rather than on the child's needs (Shaffer, 2009). Kopko (2007) used uninvolved parenting theory to focus on parenting styles specific to parents and adolescents. The purpose of this study was to examine parenting styles and their impact on adolescent development. It is intended primarily as a guide for parent

educators and other professionals working with parents of teens. In this study, Kopko (2007) found that depending on which stage of development children are in, they can be affected by uninvolved parenting in different ways. He found that authoritative parenting enhances a child's development, unlike uninvolved parenting styles. The interaction between parent and child provides clear evidence of this enhanced relationship.

Parenting styles may also be influenced by depressive symptoms in the mother. Chao (2011) studied the structure of family interaction relationship types and the differences of parent-child interactions based on parent-child samples in Taiwan. Additionally, the parenting styles could be culturally influenced. For example, in his pilot study, Chao (2011) found that the mother-child relationship does vary by cultural groups. The study included families with Taiwanese children in grades third through sixth. Research participants consisted of children with one or both parents. There were two pilot scales both with valid samples and two phases of development. The pilot scale with a valid sample consisted of 157 families and 453 families were included in the formal scale valid sample. In the pilot scale sample, there were a total of 438 participants, which included 129 fathers, 152 mothers, and 157 children. The formal scale with a valid sample included 1,347 individuals, 446 fathers, 448 mothers, and 453 children (212 males and 241 females). Of the 446 fathers, 206 fathers (46.2%) were between the ages 30 and 40, 218 (48.9%) were ages 41 through 50 and 22 (4.9%) were over the age of 51. Of the 448 mothers who participated in the study, 7 (1.6%) were between the ages 25 and 30, 295 (65.8%) were between the ages 31 and 40, 143 (32.0%) were aged from 41 and 50, and 3 (0.6%) were over age 51. Of the 453 children who participated in the study, 132

(29.1%) were 8 years old (grade 3), 101 (22.3%) were age 9 (grade 4), 113 (25.0%) were age 10 (grade 5), and 107 (23.6%) age 11 (grade 6) (Chao, 2011).

Chao (2011) used the structural equation modeling (SEM) to verify the structure of family interaction relationship types, the assess of the linear structure model and explain the fit of the observed data. SEM is a verification tool also used to verify the content of the theoretical framework and the fit of the actual observed data. Forty-four items were divided into sixteen item parcels. The sixteen parcels were derived from the eight family interaction relationship types; the results of the eight family interaction relationship types were randomly divided into two groups. The sixteen parcels were then calculated to provide sixteen indices which were then subjected to confirmatory factor analysis. This strategy was used because testing experts claim that this type of grouping has greater communality than individual items (Little, Cunningham, Shahar & Widaman, 2002). This results in a distribution of the indexes which will be closer to normal (Bagozzi & Heatherton, 1994); and provides a better model fit (Bandalos & Finney, 2001) to decrease the impact of individual items that influence the stability of observed variables and reduce the possibility of the estimated parameters being caused by the second type (Chao, 2011).

According to Chao (2011), this research study was constructed through the interaction of three sets of dimensions such as explicit/implicit expression, harmonious/inharmonious affection, and active/inactive inclination. These family interaction relationship types conform to the family interaction relationship model of Taiwanese families. Based on comparisons of the differences in family interaction

relationship types in Taiwan, no significant differences were found between sons and daughters in this study. Mothers were found to express more empathy than fathers in family interactions, but there were no significant differences in other relationships (Chao, 2011).

Parenting styles may be understood through the work of Ainsworth and Bowlby's (1978) attachment theory. They are introduced in greater detail in the next section. Attachment theory is based upon the first 12 months of life (Newman & Newman, 2003). The first life stage is zero to three months, the second is three to six months, the third is six to nine months, and the last stage is one year old and older. During the first stage, zero to three months, there are various behavioral engagements such as sucking, rooting, grasping, smiling, gazing, cuddling, and visual tracking, the ways the infant maintains a caregiver's attention. During the second stage, infants, three to six months, expression of the infant's attachment is proffered to only a few familiar faces. Attachment to mothers provides necessary care, and protects the infant from dangers and stressors so the child is able to function independently throughout development (Zastrow and Kirst-Ashman, 2004). Attachment between the father and child is important. The role of fathers and paternal distress in child development are understudied, meanwhile, primary emphasis continues to be placed on mothers, possibly because the main caregiver for the young infant is usually the mother.

In stage three, ages six to nine months, babies become mobile. Crawling away, looking back, and expecting their caregiver to be available or present while they crawl and smile while exploring occur during this life stage. If the parent does not provide the

necessary attention according to the child's developmental stage and/or needs, the infant can develop a sense of mistrust (Zastrow and Kirst-Ashman, 2004).

In the fourth attachment stage, nine to 12-month-old babies usually form an internal representation of their caregivers. Internal representation is defined as the first model of the attachment relationship. A final stage, over age two shows that various behavioral influences may fulfill the child's needs for closeness with the caregiver, such as asking to be read to prior to going to bed and asking to go places with their caregiver. The information included in this study is compiled from multiple authors and researchers who have studied maternal depression and have worked or have participated in research in the fields of social work, psychology, and/or human services (Zastrow & Kirst-Ashman, 2004).

This study explored parenting mother's self-efficacy to parent. Uninvolved Parenting Theory relates to this study because my study pertains to parenting mothers who have experienced peripartum onset depression who may benefit from parenting interventions. Sanders & Morawska (2014) found that the mental health of many parenting mothers affects her capacity to parent, which may result in a lack of ability to parent efficiently. According to Newman and Newman (2003), peripartum onset depression may cause deficiency in the mother-child relationship and the attachment between mother and child. University Health Network Women's Health Program (2003) research study provides a synthesis of the latest literature pertaining to risk factors associated with developing this condition. Postpartum non-psychotic depression is the most common complication of childbearing affecting many women and as such

represents a considerable public health problem affecting women and their families.

Risks of Inadequate Parenting

Elgar et al., (2007) found that maternal depression is associated with lower parental warmth, involvement, and monitoring by mothers, which results in negative behaviors in children, directly influenced by the mother's lack of engagement. Irvine, Biglan, Smokowski, Metzler and Ary (1999) also found that many depressed mothers parenting adolescents are more likely than non-depressed mothers to punish their child with physical discipline because depressed mothers have not been exposed to parenting skills classes. A parenting skills program was developed to educate parents about how to supervise at-risk children effectively without influencing negative factors (Irvine et al., 1999). Mustillo and Costello (2008) found evidence that the effect of time demands was partially explained by maternal depressive symptoms, less supervision, improper discipline, and less quality time between parent and child. The purpose of the study was to measure whether the parent-time effects depressed children and adolescence and whether parent-child relationship produced disadvantaged influences pertaining to economic and depression in children. This was a longitudinal study that included three cohorts ages 9, 11, and 13 years of age at intake. The children lived in an 11-county area located in western North Carolina. There was a random sample with an N=3,896 which represented 95% of contacts. The questionnaire was completed by biological mothers in more than 90% of the families and was used to assess child behavior problems (externalizing). Children with scores in the 25-percentile range (score of 20) in addition to the remaining 75%, which was 1-in-10 of those sampled, also completed detailed

interviews. Every year, the two interviewers made their home visits or visits to locations that were safe and convenient for the participants. The interviewers received training from the Department of Social Services and maintained post-interview reviews of each meeting including schedules, notes, and recordings. Age and gender were the two variables used to gain a true prevailing evaluation of the population under study. The interviewers were also residents of western North Carolina where the study was completed (Mustillo & Costello, 2008). This study found that participating parents who reflected a mean number of 0.5 time demands: 59.8% had none, 32.7% had one, and 7.5% had two or more. The mean number of time remained stable throughout the study. As for mean age for subjects, it reflects 13.08, with a range of 9-16 years old. Almost half of the weighted sample was male and about 90% was Caucasian/European American, 6.13%was African American, while 3.56% was Native American. As for socioeconomic status, almost half of the sample existed below 200% of the federal poverty line, with 3.75% reporting a recent decline in their standard of living.

Children of depressed mothers are usually at-risk of having less socio-emotional development and increased negative behaviors because of the mother's interpersonal difficulties (Beardslee, Versage & Gladstone, 1998). Patrick, Snyder, Schrepferman and Snyder (2005) found that depressed mothers and poor parenting results in improper behavior in children.

According to Lovejoy et al. (2000), earlier studies have been inconclusive as it pertains to findings related to maternal depression. In the 1960's people who suffered from depression seemed better while receiving counseling services (Hopkins, 2006).

Foster, Garber, and Durlak (2008) found that adolescents may increase challenges for mothers, by demanding modifications to their daily routines; the capacity to negotiate those modifiers is not determined in the present research. Weissman and Paykel (1974) found that mothers who experience marital conflict and difficulties interpersonally are at increased risk of depression. Conversely, depression in mothers continuing up to four years post episodes increases impairment in relationships (Rounsaville, Prusoff, & Weissman, 1980).

Assessment Instruments: Maternal Relationships and Children

One relationship assessment that is used to assess the mother-child relationship is the Crowell Relationship Assessment (Osofsky, 2011). Judith Crowell determined the models of attachment among mothers and their children. Two maternal behaviors were considered to be vital influences on attachment behaviors and responses to separation. The relationship assessment provides information about the relationship via clinical observations. The post-assessment reflects the relationship changes, the externalizing and response to changes and an evaluation of the infant-parent intervention. Along with this assessment, Crowell also observes, 8-10 minutes of free play, clean up, bubble play, 3-4 structured graduated tasks, separation, and reunion. The free play takes place in a room with a one-way mirror or a glass with a curtain, a reasonable number of toys for children (i.e., telephones, animals, a doll house with people, play food, etc.). The toys are removed after cleanup and before completing structured tasks. Ratings of poor, moderate, and good are the given to the parent and child reunion. The ratings of poor occur when the

child does not approach the mother, upon seeing her after separation, but can use some improvement (Osofsky, 2011).

Observations of positive discipline consist of environmental approval such as clapping, socialization or modeling on how to put toys in their correct place, children's response to direct commands (e.g., how to put toys away), and positive reinforcements (e.g. good job, way to go). Negative reinforcement included physical contacts that seemed inappropriate. Harmful physical contact includes forcing the child to clean up and grabbing the child. Negative discipline includes threatening the child with punishment, begging, and derogatory statements such as "You are bad, stop acting up," etc. Observers note physical aggression and the use of negative words. They also observe, frequency of the parent's eye contact with the baby, parental touch, e.g. to offer comfort, and parent communication with the child, and maternal smiles. Evaluation questions were as follows, How did the dyad relate to one another? What was the overall emotional tone? How did the caregiver relate to the child? In what way did the child relate to the parent or caregiver? The assessment includes detailed questions as follows, What strengths could be built on? and What areas need improvement? (Osofsky, 2011).

The Beck Depression Inventory

The Beck Depression Inventory (BDI) includes 21 items that determine the severity of depression symptoms. It also assesses the mood and depression relative to cognitive and somatic symptoms. The (MMPI) Scale II is used to contrast depressed and non-depressed individuals. This scale consists of 60 items, which focuses on depression symptoms such as weak morality, feelings of hopelessness, apathy, disturbance of sleep

and withdrawal from social settings. In a quantitative study by Dahlstrom, Welsh and Dahstrom (1975), differences were discovered during the study of both depressed mothers and non-depressed mothers that result in a ten percent difference (80 % to 90 %) in mother's outcome.

Previous Research Methods

There are a number of previous research methods that were used to study depression among mothers and how it impacts their parenting. I chose the qualitative research method rather than a quantitative research method, because of the type of research question that was developed the purpose of the study. This research study will explore parenting mother's experience with peripartum onset depression, social support and self-efficacy to parent. The research questions guided my decision to use the qualitative research method.

Two previous research methods that were used to study maternal depression are meta-analysis and longitudinal studies. The meta-analysis research method is used to assess the result of a study with a systematic review of findings in similar studies (Barker, 2004). According to Rubin and Babbie (2008), the longitudinal research method tests groups for a certain time period (i.e., every 3-5 years). One instrument that specifically relates to the subject of the mother's perception of parenting skills is the Parent Practices Questionnaire (PPQ). This particular questionnaire was used to measure the parent's perception on their teenage children ages 16 and 17. It includes 24 questions with 6 answer selections to choose from. The purpose of this questionnaire was to obtain

parents' true perceptions of their parenting skills. Another instrument that specifically relates to the mother's perception of parenting skills is the Primary Caregivers Practices Report (PCPR). This particular questionnaire is similar to the (PPQ); however, the parents must be parenting children ages 2 – 6 (Family Therapy Training Institute, 2009).

A qualitative research method is often used by researchers in the field of human services because of its proven significance and consistency. The quantitative research method is used for quantitative studies along with a descriptive and inferential analysis. In addition, the quantitative research method uses a numerical analysis.

A qualitative research method can be used to study maternal depression, but may need to include other information to assure that the analysis is accurate (Rubin & Babbie, 2008). According to Bretherton (1992), the first studies that were done pertaining to attachment were longitudinal and observational, such as Bowlby's collection of data on children who were hospitalized and Ainsworth's studies of mother-child attachment in 1958, 1959, and 1960.

I chose the qualitative research method to study this population because it is feasible for this study. Using the quantitative research method may be an option, but I decided to use the qualitative research method because of the purpose of my research study and the type of experimental design that is being used. I chose to study the population of mothers because they usually experience depression and accept treatment, whereas men are less often viewed as depressed and statistically are less likely to seek or accept treatment (Avison & Gotlib, 1994).

Summary and Conclusion

The literature conveys that maternal depression negatively impacts mothers and their children. It can change the lives of mothers by causing them to feel hopeless and socially withdraw from normal activities. The focus of this research study is to educate others of how maternal depression affects mothers, children, and society. This chapter provided a theoretical foundation of attachment theory and self-efficacy theory. Further, to provide and understanding of depression, a historical context was presented. Next, a focus on literature specific to depression and motherhood was provided, including a discussion on the pathological aspects of the disease. Next, maternal depression was analyzed by examining the mother-child relationship and how scholars have framed their understanding of the problem. Parenting styles were reviewed along with mothers' self-efficacy.

Maternal depression is a social issue for many individuals and families. This research study pertains to the levels of social work practice (i.e., micro, mezzo, and macro). The micro level relates to the individual's environment. The mezzo level relates to the family or interactional processes between and among varieties of microsystems. Moreover, the macro level of social work of this research study aimed to educate professionals who work with the administration or macro level to become more involved in improving the parenting skills of mothers by becoming active to make a difference in their lives.

Chapter 3: Research Method

Introduction

My purpose in this phenomenological qualitative study was to explore how mothers who have experienced peripartum onset (postpartum) depression perceive their social support and their ability to parent effectively. Stern's (1998) seminal research indicated that in the Western world, new mothers are not provided with adequate guidance to master parenting or to overcome the difficulties of self-image while adjusting to their new roles. However, these mothers are judged by others and are expected to succeed as effective parents. Gotlib and Hammin (2014) found that maternal depression affects many mothers and their child(ren). Gotlib and Hammin recommend that further research be conducted related to peripartum onset depression. This was recommended as a result of multiple significant factors the research found, which included the age of depression onset, the type of study depressions, course (duration of depression) and comorbidity. Furthermore, they presented evidence that depression adversely affects the quality of interpersonal relationships including particular, relationships with spouses, and relationships with children (Gotlib & Hammin, 2014).

Maternal depression and its effects on children were studied by researchers. Research on mothers who are depressed shows them to have a tendency to be inconsistent in parenting, withdrawn, and have ineffective parenting skills (Luoma, Kauonen, Mantymaa, Puura, Tammien, & Salmolin, 2004). Moreover, maternal depression could result in negative outcomes including poor parenting skills and a negative effect on child development from birth to adulthood (Goodman & Golib, 1999).

In this Chapter, I describe the research design and rationale. I discuss the study sample along with procedures for recruitment and participation. I also discuss the interview questions used to collect data from research participants. In the next section, I discuss the data analysis plan as well as validity and ethical considerations.

Research Design and Rationale

According to researchers (Jack 2006; Polit & Beck, 2013), in an era of evidence-based research, qualitative researchers are expected to demonstrate the validity of the findings based on the responses of research participants. I chose the qualitative method to examine parenting mothers older than 18 years who have experienced peripartum onset depression. It is feasible to interview this population of women because of common diagnosis, age, and individualized experience. Parenting mothers' response to the interview questions may vary but will be measured. The qualitative research method is needed to identify factors that affect the magnitude of parenting deficits among women who are experiencing depression and other psychological difficulties that may occur (Lovejoy et al., 2000). In qualitative research, findings vary because each of those studies has a different gap to be determined. The research question for this phenomenological qualitative study is: How do mothers diagnosed with peripartum onset clinical depression perceive their parenting skills?

Role of the Researcher

My key role as a researcher was to meet all requirements to create a scholarly research project including research design, data analysis, and evaluation. This role is critical because it reflects my understanding of my role as well as my competence and compliance with ethical guidelines. Proper record management practices applied in order to protect confidentiality and privacy based on Walden University's Institutional Review Board and ACA (2014) governance.

My role in this research study was observer. As an observer, I used an informal assessment. This type of assessment allowed me to gather information such as body language, appearance, facial expressions, and mood. As the observer, it is also essential to this study because it allowed me to ask the participant's questions and process record their response accordingly (Patton, 2002). Participants of this study did not have any acquaintance with me because this leads to ethical noncompliance. To manage research participant's eligibility to participate, I met with participants prior to collecting data. This helped me to determine whether I know the perspective participant.

As a research investigator, I displayed my trustworthiness and concern to research participants. I was sure to provide the participants with a resource list to assure safety and well-being of the mother and also ask whether I should stop the interview. This is important because this maintained rapport between the interviewee and me.

Methodology

According to Rudestam and Newton (2015), the purpose of qualitative research is to use a sample of a population, while using valid instruments that lead to data analysis, which adopt views directly held by researchers who usually conduct analysis accurately. Qualitative research differs from quantitative research because it does not measure data using numbers; it measures data using narrative evidence (Rubin & Babbie, 2008). According to Rubin and Babbie (2008), narrative data are descriptive and have to be reviewed, organized, and coded to perform data analysis. Quantitative research uses a slightly different approach and uses numbers to analyze data because its foci are numerical, and variables are used that correlate to the quantitative research questions (Rubin & Babbie, 2008).

Although the quantitative research method requires a large number of research participants, qualitative research method does not, and, therefore, the inability to attain a large number of research participants should not affect the findings of this study (Patton, 2002). The qualitative research method requires a specific or selective number of participants to be considered feasible (e.g., N =1). These data are needed to assure that findings are measurable.

According to Patton (2002), qualitative studies do not test hypotheses but instead are emergent and open-ended. Emergent pertains to the researcher's focus on the global aspect of the social problem. Open-ended questions require more thought and more than a one-word response. This study helped to achieve a measurable analysis because of the research question that lead to asking essential questions. Furthermore, the self-identified

research participants helped to determine the findings stemming from the data collection process.

The inclusion criteria for the sample included parenting mothers older than 18 years who have previously been diagnosed with depression with peripartum onset by a licensed physician. I chose to study mothers older than 18 years because this phenomenological qualitative research study needs authentic responses relative to mothers' experiences with peripartum onset depression. I recruited participants by posting flyers with my contact information in public places accessed by mothers. Prior to posting flyers, I received permission from the supervisor and/or the director of each potential agency in Baton Rouge, Louisiana, and/or surrounding areas. A copy of the flyer is provided in Appendix C.

Participants and Sampling

I used both the convenience sampling and snowball sampling to complete this phenomenological qualitative study. Convenience sampling, also known as availability sampling, is used primarily to obtain data from available subjects (Rubin & Babbie, 2008). According to Rubin and Babbie (2008), a convenience sample is used as a sampling method in the field of social work because of its inexpensiveness and feasibility for studying certain populations. Snowball sampling also known as a non-probability sampling is when one respondent leads to another, and that one refers another (Royse, 2004). According to Royse (2004) this type of nonprobability sampling grows by referrals to other potential responders. This approach is used when it is difficult to locate respondents by any other means (Royse, 2004).

This study included six English speaking women older than 18 years who have been diagnosed with peripartum onset either during pregnancy or within 4 to 6 weeks after giving birth and has at least one child younger than 12 years. Each participant was self-identified as having met these criteria, because this reduces the risk of inadvertently harming a sample of women that have been clinically diagnosed with peripartum onset depression. By having parenting mothers to self-identify helps eliminate risks of breaching confidentiality. There was no need to ask anyone else about the participant. Self-identified women differ from non-self-identified women because these women voluntarily share their experience with the researcher, whereas non-self-identified women may not voluntarily share their experiences (Rubin & Babbie, 2008).

According to Rudestam and Newton (2015), most phenomenological qualitative studies engage a relatively small number of research participants (e.g., 10 or fewer). Using the convenience sample increases the chance of finding the gap in this study because it uses empirical data from parenting mothers that can be analyzed and used for further research. According to Creswell (2008), a convenience sample allows researchers to gain specific information from subjects. I did not use randomization because the convenience sample increases the chance of finding the gap in this study because the collected data is primary. Interviewing parenting mothers eliminates the need to use randomization, which is also known as a non-probability sampling method (Hair et al, 2011). Participating parenting mothers provided responses to questions about their social support and their experiences with peripartum onset depression.

Therefore, the interview questions were non-biased and culturally sensitive, meaning questions were presented in a non-judgmental manner where mothers should not feel any sense of harm or violation. Culturally sensitive relates to a person not being viewed as right or wrong, positive or negative, or better or worse (Barker, 2014). This social work practice is an intervention that recognizes cultural differences do exist and should be acknowledged. Interviews took place at a local community library and in private meeting rooms. Interview questions are provided in Appendix A.

There is a plan to prevent participants from feeling harmed or disturbed (Corbin & Morse, 2003). If, for some reason during the data collection process any research participant becomes emotional, I would immediately stop the interview until it seems appropriate to proceed. A list of resources was available for each participant (see Appendix F). According to Corbin and Morse (2003), when participants become emotional or seem disturbed it is best to pause and let the interviewee take charge of the interview for few minutes, so the interviewer can get a better understanding of the participant's experience. Participants have the right to terminate the interview at any time.

Procedures for Recruitment, Participation, and Data Collection

Prior to collecting data from participants, I reviewed the consent forms and answered any questions. I assured that each participant agreed to participate and understood the conditions before they signed the consent form; (see Appendix D). I began the recruitment process by posting flyers at various locations; (see Appendix C). I responded to potential participants who may contact me via email. Potential participants

and I scheduled a day and time to meet to complete the interview. I determined eligibility by screening potential participants before proceeding to the interview. Consent forms were read and explained to each participant prior to obtaining signed consent forms. Email reminders will be sent close to the scheduled interview date. Interviews were conducted at a local community library. On the day of the interview, participants were given a brief overview of the purpose of the study along with the consent form to participate. The mothers who participated in this research study shared their personal experiences relating to peripartum onset depression and how it may have impacted their parenting experiences. Qualitative questions are typically open-ended and thus may result in responses that vary per participant. A demographic screening questionnaire was used to gather information from participants prior to the interview (see Appendix B).

Method Instrumentation and Operationalization of Constructs

The two types of phenomenological research approach are empirical and existential or interpretive. The empirical approach is closely descended from Husserl's philosophical position. Moustakas (1994) found that existential research relates to evidence through understanding the individual's situation or personal behaviors through interviewing. The existential or interpretive approaches draws upon Heideggar's work, who was a student of Husserl. Heideggar focused on the individual's uniqueness rather than classifying their schemes (Rudestam & Newton, 2015). Heideggar foci relate to this phenomenological qualitative research study because I too, focus on individual's uniqueness as it relates to their experience with peripartum onset.

The interview questions relate to the data analysis plan because this result in better findings. The interview questions correlate with the data analysis plan because both factors should be measurable and bring about valid findings. Furthermore, data collection was feasible and result in measurable outcomes. The interview questions that was administered to research subjects should correlate with the hypothesis of this study. This correlation helps to maintain a clear definition and purpose for the study. There are interview questions in Appendix A that specifically explored participating parenting mothers who have experience with peripartum onset depression, giving them opportunity to express personal feelings or attitudes concerning their experiences with depression and social support. The interview questions relate to the research question because specific details concerning the parenting mothers experience with peripartum onset depression. The primary data helped to obtain details needed to gather the necessary information to complete the investigation.

Member checking is basically what the term implies – an opportunity for members (participants) to check (approve) particular aspects of the interpretation of the data they provided (Doyle, 2007; Merriam, 1998). Member checks was used to clarify or to determine whether participant responses are correctly related to their interpretation. After the interview, the transcribed copies of the interview were emailed to research participants. Each participant was asked to review and make corrections to reflect accuracy. Participants were given the opportunity to review their responses via email within 5 days weeks following the interview to confirm that research participant's

responses were accurate; See Appendix A – *"Closing out the Interviewing Procedure" (Summary).*

Data Analysis Plan

According to van Kaam (1966), six steps of explication were implemented for data analysis. The six steps are: 1) classify – information is categorized prior to grouping, 2) reduction also called modification – reduces concrete or vague expressions to precise descriptive terms, 3) elimination – checking and eliminating non-relevant elements, 4) hypothetical identification – process takes place because the elimination process was not fully complete, 5) application – the formula must be revised in order to correspond with the cases used in the application, and 6) final identification – When the ions have been successfully carried out to reflect as valid. Van Kaam (1966), Stevick (1997), Colaizzi (1973), and Keen (1975) found that the second approach to analyzing qualitative data is modification. Qualitative studies use coding to classify and categorize elements of data (Rubin & Babbie, 2008). Coding is a straightforward approach, usually related to survey research. The tradition of qualitative research has its own approach to analyzing textural data. Textural data pertains to the "what" of experience, whereas a structural description refers to the "how" of the experience (Moustakas, 1994).

According to Colaizzi (1978), the phenomenological method is specifically used for analyzing the interview transcripts of research participants. An Excel spreadsheet was used to input the interview questions, data responses from participants, coding and themes. I completed two cycles of coding. The two cycles of coding were initial and focused coding (Saldana, 2016). This analysis processes the sample size for a research

study and the software helps to simplify assumptions in order to make the data tractable. It also runs the analysis numerous times with different variations to cover all contingencies (Bazeley & Jackson, 2013).

According to Rubin and Babbie (2008), in qualitative research data, cleaning and screening are necessary to complete the analysis. Both steps help prevent errors, although errors are inevitable. The researcher of this phenomenological qualitative study reviewed data from research subjects to assure the accuracy of answered interview questions and whether responses given by research subjects can be imported into the analysis program. The researcher determined whether participant responses are understood by clarifying participant's response during the interview while note taking or recording. This should make the cleaning data process less cumbersome. Cleaning data is part of the analysis standards because it helps with achieving measurable outcomes (Rubin and Babbie, 2008). The research questions in Appendix A have been designed to help address this study's research problem.

Issues of Trustworthiness

For a researcher studying the scope of mothers' experience with peripartum onset depression, the continuous aim is to assure appropriate steps are taken according to compliance with ethics of the American Counseling Association (ACA). Using various guidelines regarding integrity in the research process helps researchers maintain objectivity. As a researcher, I focused on developing a replicable study, so that others interested in this subject can duplicate my steps. Furthermore, to assure that information collected from research participants is handled with care, data is being used according to

the purpose of this research study and also safeguarded. The term *safeguard* means to protect against possible loss or danger (Merriam-Webster Dictionary, 2017). According to Rubin and Babbie (2008), replicating a research study duplicates and examines the evidence and conclusions of the study. When the researcher completes a research study as planned, to meet expectations by complying with ethics, producing readable data, and valid findings, the study should be replicable (Rubin & Babbie, 2008).

The Institutional Review Board (IRB) must adhere to ethical standards and United States Regulations. The American Counseling Association (ACA) also governs researchers prior to data collection. The ACA is included in this research study because this particular association promotes counselors through work in advocacy, research and professional standards. The American Counseling Association was founded in 1952 is the worlds' largest association exclusively representing licensed professional counselors (LPCs), counseling students, and other counseling professionals in the United States. This association also has a Code of Ethics that should be used by LPCs, counseling students and other counseling professionals. For example, according to Section G of the American Counseling Association Code of Ethics (2014), counselors and researchers are expected to be consistent with pertinent ethical principles, federal and state laws, host institutional regulations, and scientific standards governing research with human research participants. Adherence to both IRB and ACA policies reflects the integrity of researchers as well as protects participants from any harm and/or violations.

Ethical Procedures

The protection of human research participants is very important and reflects that ethical guidelines have been considered. The researcher is required to educate and inform readers of why complying with ethics is necessary. The National Institute of Health (NIH) has trained many researchers to ensure that responsible conduct is being followed. I completed an online training related on how to protection of human research participants. According to the Institutional Review Board (IRB) guidelines, the results of this study can be published without including research participant's name. Publishing without the participant's name indicates compliance with ethics. To secure research participants' files, they are stored in a secured filing cabinet for a minimum of five years. The remaining documents are being kept as a master copy or a safeguarded computer file. The master copy would not be used for copying, cutting or pasting. The necessary measures taken to maintain privacy are protecting documents from others who are not authorized to access those files. Participant numbers and pseudo names are used to protect identities. To guarantee that I am a competent researcher, I completed the National Institutes of Health - *Protecting Human Research Participants* training on April 18, 2018.

Summary

In this chapter, the research design and rationale, role of the researcher, methodology, sampling and sampling procedure, procedures for recruitment, participation and data collection were presented. The method instrumentation and operationalization of constructs, operationalization of variables, data analysis plan, issues

of trustworthiness along with ethical procedures were also explained. Those concepts were included in this chapter to present readers with a clear knowledge of the research methods for this study. The following chapter will present the findings after the data collection has been completed. In Chapter 4 the reader will become familiar with the outcome of the study after research participants respond to the qualitative interview questions.

Chapter 4: Findings of the Research Study

Introduction

My purpose in this phenomenological qualitative study was to explore how mothers who have experienced peripartum onset (postpartum) depression perceive their social support and their ability to parent effectively. The research question for this phenomenological qualitative research study was: How do mothers diagnosed with peripartum onset clinical depression perceive their parenting skills?

In this chapter, I will discuss the findings of this research study in specific detail related to the setting, demographics, data collection, data analysis, evidence of trustworthiness, results, and summary of the study.

Setting

I conducted six interviews for this phenomenological qualitative study. As the research investigator, I allowed potential participants to choose their preferred type of interview (i.e., in person or phone). Five out of six of the interviews were in person and I only conducted one interview by phone. The interviews took place in private offices and private meeting rooms in libraries in the north and southeast areas of Louisiana during March and April 2019. Furthermore, research participants chose a specific date and time to be interviewed. After obtaining potential participants' verbal approval, I noted each appointment accordingly on work calendar.

Demographics

The demographics and characteristics of the mothers who were self-identified for this study ranged from 23 to 39 years old. Each participant met the criteria to participate in this study. The criteria to participate in this study included the following: mothers had to be English-speaking, older than 18 years, with a diagnosis of depression during or after giving birth and are no longer receiving treatment and are parenting at least one child younger than 12 years. Five participants completed one-time face-to-face interview for an estimated time of 45 minutes to 1 hour. One mother completed a phone interview. This phone interview was completed in an estimated time of 25 minutes.

Table 1

Summary of Participant Demographics

Research participant	Age with onset of depression (years)	Disclosed number of children	Participant's relationship status
Blue Zircon	23	3	Married
Peridot	30	1	Undisclosed
Opal	30	3	Married
Pink Tourmaline	33	3	Married
Pearl	39	1	Undisclosed
Blue Topaz	34	3	Married

Note. Research participant names in Table 1 were changed to assure confidentiality.

Data Collection

I interviewed a total of six research participants in private meeting rooms. I conducted research in the months of March and April 2019. I interviewed three participants from the north area of Louisiana and 3 participants from the southeast area of Louisiana. The research instrument used was an interview. The average length of time for each interview was 25 to 30 minutes. The third interview was a phone interview, which occurred in a private meeting room. I conducted the fourth and fifth interviews in person and in private meeting rooms in an office in the southeast area of Louisiana. The last interview was also in person and was held in a private meeting room in the southeast area of Louisiana. These participants were self-identified prior to partaking in the interview. Therefore, all self-identified participants met the research criteria.

The data was recorded individually because each interview took place in person or via phone with me at a scheduled appointment time. To record the data throughout the interview, I manually recorded the responses to each question that I asked. I also voice recorded the interviews only if the participant circled *Yes* on the consent form and provided their initials. As the research investigator, I explained to each research participant the interview procedure and protocol verbally and allowed them to read the consent form and ask any questions prior to and following the interview. I used social media (Facebook) and the snowball method to recruit research participants. I also held two postpartum depression seminars. I facilitated seminars on December 15, 2018 and March 7, 2019, which were available to the public at no charge. Using those recruiting strategies were successful. I obtained one self-identified participant with social media

(Facebook), two participants by word of mouth, one participant from my postpartum depression seminar, and two self-identified participants with the snowball method.

Data Analysis

To begin the data analysis process, I reviewed each research participants' response addressed by the interview questions. Member checks was used to ensure accuracy of research participants' responses. I used Microsoft Word to create a table to input the demographics of each research participant. The demographics consisted of research participant's pseudo name, their age when they experienced peripartum onset (postpartum) depression, their number of children and their relationship status. The table was shown previously as Table 1. An Excel spreadsheet was used to input the interview questions, data responses from participants, coding and themes. Eight themes were identified that addressed interview questions. I completed two cycles of coding. The two cycles of coding were initial and focused coding (Saldana, 2016). This table is shown as Table 2.

The qualitative method considered was phenomenological. This inductive process consists of interviewing a small sampling of participating mothers over the age of 18 in the north and southeast areas of Louisiana. The data analysis process included interpreting data collected, obtaining data saturation and analyzing participants' transcripts. As the result of the data analysis I identified eight themes: Recognition of Depression, Symptoms Noticed, Frequency/Length of Depression, Coping Strategies, Impact on Parenting, Supports Received, Results of Social Supports, and Last Feelings of Depression.

Table 2

Specific Codes, Categories, and Themes Identified from the Data

Themes
Theme 1: Recognition of Depression
Theme 2: Symptoms Noticed
Theme 3: Frequency/Length of Depression
Theme 4: Coping Strategies
Theme 5: Impact on Parenting
Theme 6: Supports Received
Theme 7: Results of Social Supports
Theme 8: Last Feelings of Depression

Note. The eight themes in Table 2 resulted from the data analysis.

Theme 1: Recognition of Depression

Theme 1 addressed the following interview question: Who was the first to mention to you that they noticed your depression? I asked each research participant this question to attain a better knowledge of each participants' recognition of their depression. Each participant's response informed me of who recognized their depression initially before receiving any social supports.

- Blue Zircon stated, "Nobody really noticed my depression."
- Peridot stated, "Nobody else noticed my depression."
- Opal stated, "Nobody else noticed my depression."
- Pink Tourmaline stated, "Nobody else noticed my depression."
- Pearl stated, "My mother was the first to notice my depression."
- Blue Topaz stated, "My husband was the first to notice my depression."

The data I gathered revealed slightly similar responses from each research participant. For example, 4 out of 6 research participants or 66% stated that nobody noticed their depression and 2 out of 6 research participants or 33% stated that a family member or their spouse noticed their depression.

Theme 2: Symptoms Noticed

Theme 2 addressed the following interview question: What were the first symptoms you experienced with your depression? I asked each research participant this question to gather data pertaining to typical symptoms related to peripartum onset (postpartum) depression.

- Blue Zircon stated, “My first symptoms were anger, rage and exhaustion.”
- Peridot stated, “My first symptoms were loneliness and helplessness.”
- Opal stated, “My first symptoms were feeling anxious and real tired (fatigued).”
- Pink Tourmaline stated, “My symptoms were not wanting to do nothing, could not stop crying, and was very exhausted.”
- Pearl stated, “I noticed that I was depressed when I did not want to hold my baby after giving birth.”
- Blue Topaz stated, “I did not notice my depression.”

Although each research participant’s responses varied, I was able to distinguish between typical symptoms according to the *Diagnostic and Statistical Manual of Mental Disorders 5th Edition, (2013),* also known as the *DSM-5*. As stated in Chapter 2 of this research study, some symptoms are internalized through withdrawal, anxiety, and somatic discomforts. *The DSM-5;* (*Diagnostic and Statistical Manual of Mental Disorders 5th Edition,* 2013), delineates mild, moderate, and severe depression. Mild depression includes symptoms that can be repressed by sensory stimulus or distraction. Mild symptoms can be distressing, but manageable and result in only minor impairment in social or occupational functioning. Moderate depression includes symptoms that require explicitly protective measures and behavioral modifications. Moderate symptoms fall between those specified for “mild” and “severe.” Symptoms are considered moderate that are less long-term than severe symptoms. Severe depression includes symptoms that are considered long-term or chronic. Severe symptoms are seriously distressing and unmanageable, and markedly interfere with social and occupational functioning.

Long-term means at least two years. Other symptoms are externalized as behavioral excesses, such as breaking rules and exhibiting aggressive behaviors (Wilmshurst, 2013). Parenting mothers who experience recurring depression, are usually experiencing stressors such as inadequacy in their finances and lack of positive relationships (National Research Council and Institute of Medicine, 2009). My research data show that all research participants experienced all 3 levels of depression (i.e., mild, moderate, and severe).

After analyzing the data, 3 out of 6 participants or 50% seem to have experienced mild depression and 2 out of 6 participants or 33% seem to have experienced moderate depression. One out of 6 participants or 16.5% seem to have experienced severe depression. For example, Peridot, Opal, Pearl experienced mild symptoms of depression. Blue Zircon and Pink Tourmaline both experienced moderate levels of depression. Lastly, Blue Topaz seemed to have experienced severe depression.

Theme 3: Frequency/Length of Depression

Theme 3 addressed the following interview question: Could you tell me how long did your depression last and how often did your depression episode last? I asked each research participant that question to explore their lived experience with peripartum onset (postpartum) depression. Although research participants shared how long their depression symptoms and/or how long episodes lasted, their responses did vary.

- Blue Zircon stated, “My depression lasted for about 4 weeks postpartum. I do not know how long my depression episodes actually lasted.”
- Peridot stated, “My depression lasted for about 3-4 weeks postpartum. My depression episodes varied day by day.”
- Opal stated, “My depression lasted for about 6 months to a year. My depression episodes varied each day.”
- Pink Tourmaline stated, “My depression did not last very long; depression lasted about 4 months. I did not work for 3 ½ months. I was back to myself within 4 months. I became proactive enough to go back to work.”
- Pearl stated, “My depression lasted for about 2 months.”
- Blue Topaz stated, “My depression lasted for 3 years. I kept experiencing relapses.”

The data from Theme 3 above showed 2 out of 6 research participants or 33% stated that their depression lasted about three to four weeks. Two out of 6 research participants or 33% stated that their depression lasted about 2 to 4 months. Lastly, two out of 6 participants or 33% stated that their depression lasted for at least 6 months to over a year. The frequency/length of depression as stated by the Diagnostic and Statistical Manual of Mental Disorders (2013) stated that the pattern of onset and remission of episodes must have occurred during at least a 2-year period, without any non-seasonal episodes occurring during this period. In addition, the seasonal depressive episodes must substantially outnumber any nonseasonal depressive episodes over the individual’s lifetime. My findings show that research participant’s depression lasted in

the pattern of onset and remission of episodes occurred in the same length and time period described in the Diagnostic and Statistical Manual of Mental Disorder; (*DSM-5*, 2013).

Theme 4: Coping Strategies

Theme 4 addressed the following interview question: What did you do to cope during your episode with peripartum onset depression? I asked this question to achieve data related to each research participant's coping regimens during their lived experience with peripartum onset (postpartum) depression.

- Blue Zircon stated, "I used postpartum depression trainings and doctors were supportive."
- Peridot stated, "I would go in the other room, breathe and regroup."
- Opal stated, "To cope during a depression episode, I would meditate ask my mother to help by watching my children while I take some time to rest or have a little self-time."
- Pink Tourmaline stated, "I would allow my mother to help me with feeding my baby and making sure the baby was being taken care of."
- Pearl stated, "I would deep breathe, meditate, and remember the things I was taught. I would also be to myself sometimes."
- Blue Topaz stated, "I would pray and be honest expressing my feelings with others. Not hiding my feelings and expressing what I needed."

Coping regimens varied per research participant. For example, Blue Zircon used self-help trainings and support from doctors. Peridot, Pearl and Opal used breathing

techniques and regrouping as coping regimens. Pink Tourmaline and Opal received helped from their mother. Pearl and Blue Topaz both used meditation as part of their coping regimen. This indicated that each research participant used coping strategies that they considered necessary during their lived experience with peripartum onset (postpartum) depression.

Theme 5: Impact on Parenting

Theme 5 addressed the following interview question: Do you believe that your depression impacted your ability to parent? If so, how? Each research participant was asked this question to obtain authentic data related to their self-efficacy to parent. As I stated in the Literature Review of Chapter 2, self-efficacy theory focuses on and individual's belief in his or her capabilities to organize and execute the courses of action required to manage prospective situations. Furthermore, this theory also reflects the mother's confidence to parent effectively (Bandura, 1995). The following are responses from each research participant concerning their impact on parenting.

- Blue Zircon stated, "Yes, my depression impacted me. The treatment stopped for 4 months. Initially, the depression caused me to have someone to watch the kids while shopping and completing other necessary tasks. I did not have the energy to work; I felt very isolated, exhausted, unhappy, and irritable. I would also yell at others and become short tempered."
- Peridot stated, "No, I do not believe my depression impacted my ability to parent."

- Opal stated, “No, I do not believe that my depression impacted my ability to parent.”
- Pink Tourmaline stated, “No. At first, I did not believe that my depression impacted my ability to parent. My depression impacted my ability to parent, because I was dealing with obsession (my depression) and my baby would be depending on me and I would be crying and feeling sad and depressed. However, but after experiencing depression post pregnancy, I believe so.”
- Pearl stated, “At first, because my mother would help me with taking care of my baby (i.e., feeding etc.”).
- Blue Topaz stated, “Yes, my depression impacted my ability to parent. My children were born close in age. Therefore, my first born had to help with her two siblings because she knew that I was unable to parent because of my depression. I was emotional at times. I could not remember my last-born development experiences. I also procrastinated a lot too.”

Responses given from each research participant showed that, 2 out of 6 participants or 33% replied “no” and 4 out of 6 research participants or 67% replied “yes” to the question do you believe that your depression impacted your ability to parent? If so, how? Those replies reflect that most of the participants believe that their depression impacted their parenting. This is because 4 out of 6 research participants or 67% received support from their family, spouse, friends or other social supports. Furthermore, this caused those participants to possess this perception.

Self-efficacy and parenting are vital elements that may affect the parent-child relationship. According to the data I collected from research participants, their self-efficacy was impacted. Furthermore, research participant's responses were clear and specific to their lived experience with peripartum onset (postpartum) depression.

Theme 6: Supports Received

Theme 6 addressed the following interview question: What social support (e.g., family, resources, or professional services), did you receive? Each research participant was asked that question with an aim to investigate their experience with peripartum onset (postpartum) depression.

- Blue Zircon stated, "I received support from both my best friend and my husband along with counseling."
- Peridot stated, "My mom helped me a lot throughout my experience with depression. I did not receive any support from other resources or professional services."
- Opal stated, "My husband and other family members were able to help me."
- Pink Tourmaline stated, "My mom helped me a lot throughout my experience with depression. I did not receive any support from other resources or professional services. Although my older sister worked at night, she was willing to help too."
- Pearl stated, "My mom helped me to understand what I was going through. I did not use any support groups."

- Blue Topaz stated, “My husband and my older daughter helped me a lot. My co-workers also helped me by showing concern and by not giving up on me. I also received group therapy, parenting therapy, and talk therapy from co-workers.”

Based on the responses I gathered from research participants, support from family members, spouse, friends, co-workers, doctors, self-help groups (postpartum trainings) were received. Blue Zircon and Blue Topaz received support from their spouse, family members and professional counseling services. Blue Topaz also received talk therapy from her co-workers, which was also helpful to her. Peridot, Pink Tourmaline and Pearl received support from their mother only. Therefore, 3 out of 6 research participants or 50% received supports such as group therapy, parenting therapy, talk therapy, psychotherapy (counseling). Likewise, 3 out of 6 research participants or 50% received support from only their mother.

Support groups are also in inclusive environment and help mothers to feel accepted, understood, and validated in their struggles with depression. As I stated earlier, psychotherapy (counseling) is still one of the leading types of treatment for peripartum onset (postpartum) depression. Online or in-person trainings are also helpful and supportive to mothers suffering from peripartum onset (postpartum) depression. Postpartum Support International (PSI) consists of online support groups. Participants can visit https://www.postpartum.net to register and/or join an online support groups and for additional resources needed.

Theme 7: Results of Social Supports

Theme 7 addressed the following interview question: How were those services helpful to you? I asked each research participant this question to attain data to determine whether their supports received were efficient or helpful during their lived experience with peripartum onset (postpartum) depression.

- Blue Zircon stated, "Those sources were helpful to me, because it helped me to want to go places again, not shut my family out anymore and feel better about being a parent."
- Peridot stated, "No other sources helped me; I did not receive any other social support."
- Opal stated, "I did not receive any other social supports other than my family."
- Pink Tourmaline stated, "No other sources helped me; I did not receive any assistance from other sources or professional services."
- Pearl stated, "I was prescribed a hormone. I also used yoga exercises to help me through my depression. I also drank tea for relaxation."
- Blue Topaz stated, "Those services helped me to cope and feel better."

As a result of the data I collected from each research participant, social supports received were successful. Three out of 6 research participants or 50% received social supports, 2 out of 6 research participants or 33% did not receive any other social supports other than their family and 1 out of 6 research participants or 16.5% received support from their doctor (hormone prescription) along with recreation and tea as a beverage. The data I collected from research participants reflected that social supports along with

support from their family, spouse and/or friends met their needs while experiencing peripartum onset (postpartum) depression.

Theme 8: Last Feelings of Depression

Theme 8 addressed the following interview question: When was the last time you felt depressed? I asked each research participant this question to collect accurate responses as it relates to participants' last feelings of depression that may have occurred since their pregnancy or after giving birth.

- Blue Zircon stated, "The last time I felt depressed was after my third pregnancy in 2017."
- Peridot stated, "I have not felt depressed since my pregnancy."
- Opal stated, "The last time I felt depressed was when my daughter was about two years old. My last child was growing up and I knew that she was my last child that I was going to birth."
- Pink Tourmaline stated, "I have not felt depressed since my last pregnancy."
- Pearl stated, "I have not felt depressed since my last pregnancy."
- Blue Topaz stated, "I began to feel depressed again January 2019. This occurred because I am also parenting a non-biological daughter. She is in my custody because of her mother's living situation. She is 19 months old and she cried so much in the beginning. This affected me and caused me to slightly relapse."

Three out of 6 research participants or 50% did not feel depressed since their pregnancy. However, 2 out of 6 research participants or 33% did feel depressed after their

pregnancy. The data also reflected that 1 out 6 research participants or 16.5% experienced recurring depression since their last pregnancy.

Summary of Themes

The 8 themes from this research study were recognition of depression, symptoms noticed, frequency/Length of depression, coping strategies, impact on parenting, supports received, results of social supports, and last feelings of depression. Research participants of this study revealed their lived experience with peripartum onset (postpartum) depression. The responses from each research participant were expected to be true and personal. Responses of the participants seem authentic and answered the research question found in Chapter 1.

Evidence of Trustworthiness

This phenomenological qualitative research study represented evidence of trustworthiness through the application of *credibility, transferability, dependability and confirmability*. According to Davis & Buskist (2008) credibility refers to whether results of the research are believable from the perspective of participant in the research. Transferability is the demonstration that the applicability of one set of findings to another context rests more with the investigator who would make that transfer than with the original investigator (Davis & Buskist, 2008).

Credibility

Credibility was established using member checks. At the close of each interview, I restated to each research participant that the interview will remain confidential. Participants received a transcript of their responses via the e-mail address provided on their consent form within 3 days following the interview. Once, they received the member check participants were given up to 5 days to confirm if changes were needed or not. Only one research participant responded to the member check.

Transferability

This research study demonstrates transferability. Each interview was properly conducted mirroring the Interview Procedure found in Appendix A. I began the data collection process when I received Institutional Review Board (IRB) approval on 09/27/2018. The Walden University Institutional Review Board (IRB) approved the research protocol which included the necessary documents found in Appendixes B-G. The methodology of this study can be transferable and applicable to another setting or group of people. This may be demonstrated by other research investigators who may wish to reiterate another study but make sensible judgement responsibly.

Dependability

According to Davis & Buskist (2008) dependability pertains to whether the same results would be obtained if observations could be made of the same thing twice. This study validates dependability because it is proven in the background information, literature review, methodology and data presented in this study. According to Davis & Buskist (2008) the participants were given the opportunity to ask questions about the

consent and interview procedure prior to signing the consent form. I explained to each participant the protocol of the interview. The Resource List found in Appendix E was also given to each mother prior to starting the interview process. I obtained consent prior to voice recording each participant. I followed the interview procedure thoroughly to assure participants were informants of the whole interview process. The same results may be obtained if interviews could be made again. The results of this study may be replicated.

Confirmability

An informant feedback or respondent validation, which is known as *member check* was used for this research study. According to Rubin & Babbie (2008) member check occurs when researchers ask the participants in their research to confirm or disconfirm the accuracy of the research observation and interpretations. While using member check, only 1 out 6 research participants or 16.5% responded to the member check via the e-mail address provided on the consent form.

Results

Eight themes were identified as a result of the data collection phase of this research study. The 8 themes identified were: recognition of depression, symptoms noticed, frequency/length of depression, coping strategies, impact on parenting, supports received, results of social supports, and last feelings of depression. The findings of this study reflected mothers who experienced peripartum onset (postpartum) depression. The interview question I asked each research participant that addressed Theme 5 was do you believe that your depression impacted your ability to parent? The research question for

this study*, How do mothers diagnosed with peripartum onset clinical depression perceive their parenting skills was also addressed.* The results of this study revealed that 2 out of 6 research participants or 33% stated that their depression did not impact their parenting while 4 out of 6 research participants or 67% stated their depression impacted their parenting. Furthermore, those mothers stated that the depression impacted their parenting because they had to receive various social supports such as postpartum trainings, talk therapy and psychotherapy (counseling).

Summary

Chapter 4 of this phenomenological qualitative research study consisted of six parenting mothers who have experienced peripartum onset (postpartum) depression either during pregnancy or after giving birth. As a result of data collection and data analysis, the research investigator found that each research participant's response varied, but their responses contributed greatly to this phenomenological qualitative research study. The findings of this study revealed that many women experience depression either during or after their pregnancy. The results of this study also revealed that 2 out of 6 research participants or 33% stated that their depression did not impact their parenting while 4 out of 6 research participants or 67% stated that their depression impacted their parenting. Furthermore, those mothers stated that the depression impacted their parenting because they had to receive various social supports such as postpartum trainings, talk therapy and psychotherapy (counseling). In Chapter 5, the interpretation of the findings, limitations, recommendations, implications and conclusion of the study are provided.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

My purpose in this phenomenological qualitative study was to explore how mothers who have experienced peripartum onset (postpartum) depression perceive their social support and their ability to parent effectively. The key findings of this study were based on eight themes. The eight themes were (a) recognition of depression, (b) symptoms noticed, (c) frequency/length of depression, (d) coping strategies, (e) impact on parenting, (f) supports received, (g) results of social supports, and (h) last feelings of depression. I conducted one-time interviews. After collecting data, I analyzed each participants' response to each interview question.

The findings of this study revealed that many women experience depression either during or after their pregnancy. The results of this study also revealed that two out of six research participants, or 33% stated, that their depression did not affect their parenting, whereas four out of six research participants, or 67%, stated that their depression affected their parenting. Furthermore, I addressed the research question: How do mothers diagnosed with peripartum onset clinical depression perceive their parenting skills? Mothers stated that the depression impacted their parenting because they had to receive various social supports such as postpartum trainings, talk therapy, and psychotherapy (counseling).

Interpretation of the Findings

Ineffective parenting determined that the mother's depression does affect the mother-child relationship. My research study findings showed that mothers perceived that their parenting skills were affected by their depression because they had to receive social supports. As stated in Chapter 4, three out of six participants, or 50%, received support from their mother only, whereas three out of six participants, or 50%, received supports such as postpartum trainings, talk therapy, and psychotherapy (counseling). Fifty percent of participants stated that their parenting was affected by their depression because they had to receive social supports. However, my research findings showed that mothers' depression did impair their relationship with their child(ren) and family members. For example, three out of six participants, or 50%, stated that their parenting was negatively affected. According to Rounsaville, Prusoff, and Weissman (1980), depression in mothers continuing up to 4 years postepisodes increases impairment in relationships. The data related to Theme 3: Frequency/Length of Depression revealed two out of six research participants, or 33%, stated that their depression lasted approximately 3 to 4 weeks. Two out of six participants or 33% stated that their depression lasted approximately two to four months. Last, two out of six participants, or 33%, stated that their depression lasted for at least 6 months to longer than 1 year.

Previous researchers' findings are significant because I also used the qualitative research method to obtain data. The findings of previous researchers and my findings regarding symptoms exhibited by depressed mothers were similar. For example, in Brummelte (2016), pregnancy and postpartum depression were associated with an

increased risk for developing ongoing depressive symptoms in women. Maternal attachment, sensitivity, and a positive parenting style are essential or the health maturation of an infant's social, cognitive and behavioral skills. Likewise, my research findings showed that mothers related to Theme 2, which were the symptoms noticed, anger, rage, exhaustion, anxious, loneliness, helplessness, and not wanting to hold the baby affected by their parenting during pregnancy (peripartum), upon giving birth and/or up to 2 years after giving birth (postpartum). Many mothers who are depressed lack adequate parenting skills and are often considered incapable, because of their mental health condition (Rani, 2006). Mothers who participated in this research study shared that they were unable to tend to their child(ren) because of the symptoms and frequency/length of their depression.

The conceptual framework in this study is the self-efficacy theory. The self-efficacy theory was developed by Bandura, believing it could help prevent relapse to negligent behavior (Cherry, 2016). As stated in Chapter 2, the self-efficacy theory emphasizes the role of observational learning, social experience, and reciprocal determination in the development of personality. According to Bandura (1994), the self-efficacy theory is important to parenting because self-efficacy increases the quality of mother-child relationships. The impairment of a child's academic achievement and the expression of negative behaviors also stem from lack of parental self-efficacy (Bandura, 1977).

For example, Yap and Baharudin (2016) also completed a research study including the self-efficacy theory. The purpose of this study was to examine the

mediating roles of academic self-efficacy, social self-efficacy, and emotional self-efficacy on the relationship between parental involvement (i.e., paternal involvement) and subjective well-being (i.e., positive affect, negative affect and life satisfaction) of Malaysian adolescents. I also examined mother's self-efficacy as it relates to their parenting in my research study.

Although Yap and Baharudin's (2016) study examined the parental involvement and subjective well-being of Malaysian adolescents, my research study did not include adolescents. For example, Theme 1, Theme 2, and Theme 5 in Chapter 4 addressed recognition of depression, symptoms noticed and influence on parenting. My findings showed that mothers' depression during or after pregnancy affected their ability to parent, which disrupted parenting and may cause adverse outcomes in child(ren).

The findings of this phenomenological qualitative research study gathered through careful methodology and data collection analyzed and synthesized confidential interview questions presented to each participant. The research question was: How do mothers diagnosed with peripartum onset clinical depression perceive their parenting skills? The findings of this research question revealed that peripartum onset (postpartum) depression affected four out of six participants', or 67%, ability to parent, whereas two out of six participants, or 33% perceived, that their parenting were not impacted. My research study findings showed that mothers' depression negatively affects parenting, which resulted in receiving social supports such as postpartum trainings, talk therapy, and psychotherapy (counseling).

Limitations of the Study

The limitations of this research study included the use of a small sample size. The qualitative research method uses a smaller number of research participants. Another limitation of this research study was the difficulty and length of time to obtain research participants due to their reluctance to participate for reasons unknown. Last, not being able to obtain research participants through managers, directors, coordinators, and hospitals due to compliance with HIPAA of 1996.

Recommendations

I recommend that further research related to mothers who experienced peripartum onset (postpartum) depression be considered because of the influence on parenting. This may lead to a better knowledge and understanding among research investigators and other human services professionals about the peripartum onset (postpartum) depression effects on parenting. Further research should include more efficiency in how human services professionals address mothers during their pregnancy and postpregnancy related to peripartum onset (postpartum) depression. I also recommend that more administrators, coordinators, directors, managers of agencies, and hospitals be less resistant and more supportive of qualified research investigators conducting research studies on peripartum onset (postpartum) depression's influence on parenting.

Implications

According to Cummings and Davies (2006), studying maternal depression is significant because of its frequency and adverse possible influence on parenting and children. As I stated in Chapter 1, according to Cummings and Kouros (2009), parenting has become a major concern because of the global changes that affect parenting and the relationship between the mother and her child(ren). Leahy-Warren et al. (2011) reflects that the gap in the literature identified still exists. The gap in the literature was to understand parental efficacy as it relates to the influence of depression and the role of social support networks. My research study extends the work of Madison (2014), who also examined maternal depression and indicated that there was a future need to understand parental efficacy as it relates to the influence of depression and the role of social support networks.

The potential impact for positive social change at the individual level relating to peripartum onset (postpartum) depression should be influential. For example, new mothers, as well as parenting mothers, need to know how peripartum onset (postpartum) depression impacts their parenting, daily activities, family and/or relationships. By new mothers and parenting mothers being aware, this helps to reduce the risk of harm to themselves, their child, and/or others. The potential impact for positive social change at the family level is likely to increase healthier or sustained family relationships and better involvement among each member. The potential impact for positive social change at the organizational level is likely to result in better knowledge and understanding among administrators, healthcare professionals and human services professionals. The potential

impact for positive social change at the at the societal/policy level should result in better community awareness and better knowledge and understanding of peripartum onset (postpartum) depression. By the societal/policy level having a better knowledge and understanding of peripartum onset (postpartum) depression reduces the stress on mothers relating to policy making and legislature to preserve and benefit these mothers. New mothers, parenting mothers and others in communities need policy makers and legislatures who support the betterment of society as a whole.

Conclusion

I conducted this study to explore how mothers who have experienced peripartum onset (postpartum) depression. The research question of this study was how do mothers diagnosed with peripartum onset clinical depression perceive their parenting skills? My research study findings showed that mothers' depression negatively impacts parenting which resulted in receiving social supports such as postpartum trainings, talk therapy and psychotherapy (counseling).

Eight themes emerged as a result of the data collection phase of this research study. The 8 themes that emerged were: recognition of depression, symptoms noticed, frequency/length of depression, coping strategies, impact on parenting, supports received, results of social supports, and last feelings of depression. Based upon the data collected in this study mothers parenting is impacted as a result of their lived experience with depression. This present study recommended that more administrators, coordinators, directors, managers of agencies and hospitals be less resistant and more supportive of qualified research investigators conducting research studies on peripartum onset

(postpartum) depression impact on parenting. Healthcare and practice are both essential. Research on peripartum onset (postpartum) depression should be taken into consideration for all mothers when policies are being implemented and/or modified.

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Appendix A: Interview Procedure

Depression with Peripartum Onset (Postpartum Depression) and Mother's Perceptions of Social Support and Self-Efficacy for Parenting

To the Research Participant: This research study is concerning you and your thoughts and experiences related to depression with peripartum onset and your perceptions of self-efficacy for parenting. To concentrate throughout this process, please do not become anxious or concerned about the details you disclose, because all forms you have completed, information that you disclose, and all other completed documents will be safeguarded and treated as confidential.

A. Are you in agreement to proceed with this interview process? If so, today we are here to talk about your experience with clinical depression with peripartum onset as it relates to social support and self-efficacy for parenting. Many women suffer from various types of depression, but depression with peripartum onset is one type of depression often develops in expecting mothers after giving birth.

- Could you tell me what age and/or when did your first experience with depression occur?
- When did you first notice you were feeling depressed?
- What were the first symptoms you experienced with your depression?
- Who was the first to mention to you that they noticed your depression?
- When were you first diagnosed by a physician with depression?

B. Could you tell me how long did your depression last and how often did your depression episode last? How long did it take you to realize that help was needed?

Furthermore, what did you do to cope during your episode with peripartum onset depression?

A. Do you believe that your depression impacted your ability to parent? If so, how?

B. What social support (e.g., family, resources, or professional services), did you receive? How were those services helpful to you?

C. Are there other sources of support that might have been helpful to you?

D. Could you give a description of the social supports you received?

E. When was the last time you felt depressed? How did you overcome those feelings?

Interview Questions

Question 1: What advice or suggestions would you give other mothers who have experienced depression during pregnancy or after giving birth?

Question 2: Could you give someone your reasoning of how your parenting would have been better if you had not experienced depression during and/or after pregnancy?

Questions 3: If you could change one thing about your social support that you received what would it be?

Question 4: Do you have any questions for me?

Question 5: Are there any particular questions that you would have liked me to ask you?

Closing out the Interviewing Procedure (Summary):

Examine next steps (i.e., the collected data will be transcribed. Participant will be contacted if additional information is requested). Participants will have the opportunity to review their responses via email within 3 days following the interview to confirm that research participant's responses are accurate. Participants should take about 15 minutes to review the summary.

- Clarify Confidentiality
- Read and explain referral list provided prior to the interview to assure that the participant is fully aware of the process
- Alert participant of contact information located on the informed consent form.
- Explain how research report will be handled
- Thank the participant, if necessary, receive follow-up information, and release participant
- Record any follow-up note(s).

Appendix B: Demographic Screening Questionnaire

Depression with Peripartum Onset (Postpartum Depression) and Mother's Perceptions of Social Support and Self-Efficacy for Parenting

Interview Identifier/Code: _____ Date: _____

This form is used to screen potential participants to confirm that they meet the criteria for participation in this study.

This study is designed to focus specifically on individuals who are suited to answer this study's research questions, without creating any discomfort for any participant. Today, I would like for you to answer a few questions to determine if you meet the criteria to participate in the interview process.

The following will be read to potential participants for criteria screening:

- Participant should be a self-identified, English-speaking mother over the age of 18.
- Participant should reside in Baton Rouge, Louisiana or the surrounding area.
- Participant should be a mother who has been medically diagnosed with depression during pregnancy and/or postpregnancy.
- Participant should be parenting at least one child under the age of 12.

Rejection Criteria

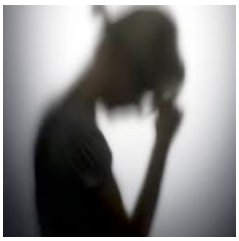
You are unable to participate if:

Research participant is not older than 18 years, is not English-speaking, is a student, client, or employee of the researcher and participant, and participant is not parenting child(ren) under the age of 12. If you meet the criteria to partake in this study and would

like a private interview, I will schedule an interview at this time. On the day of the interview, I will explain details of the study including the informed consent.

Appendix C: Research Flyer

Volunteers Needed!



Research Study:
Depression with
Peripartum Onset
(Postpartum Depression)
and Mother's Perceptions of
Social Support and
Self-Efficacy for Parenting

IRB#
01-02-19-0222909

Do you meet the criteria to participate?

- Are you an English-speaking mother over the age of 18?
- Do you reside in Baton Rouge, Louisiana or the surrounding area?
- Are you a mother who was diagnosed with clinical depression post-pregnancy within 4-6 weeks after giving birth?
- Are you parenting at least one child under the age of 12?

For more details concerning this study, contact the researcher specified on this flyer.

Are you or do you know of any mothers who suffered with depression during pregnancy or post pregnancy within 4-6 weeks after giving birth?

If so, please consider participating in an interview with me in a private, confidential interview to share your experiences for a research study.

This study is conducted to understand a mother's experience with depression and how it impacts her parenting skills.

Participants are asked to:

- Provide informed consent (grant permission and acknowledge any risks and benefits).
- Complete an in person confidential interview lasting from 45 minutes to 1 hour.
- Share your experience about depression during and/or after pregnancy
- **Note:** Participation is voluntary and possible compensation.

Contact Researcher

Name: Shenetha Ramsey, Walden University

E-mail: shenetha.ramsey@waldenu.edu

Appendix D: Informed Consent Form/Statement of Consent

Depression with Peripartum Onset (Postpartum Depression) and Mother's Perceptions of Social Support and Self-Efficacy for Parenting

Principal Investigator: Shenetha C. Ramsey

This form of agreement also called *"informed consent*" is used to obtain your written permission to participate as a research participant in this study. This research study explores women over the age of 18 who have been diagnosed with peripartum onset will self-identify as having met the criteria to participate in this research study. Parenting mothers' perceptions of their social support will be explored. By completing this study, you will contribute to assisting human services professionals' understanding of maternal depression and how it might impact their parenting. Depression with peripartum onset may impact mothers during their pregnancy, after giving birth and while parenting. The inclusion criteria for this study are:

- Participants should be a self-identified, English-speaking mother over the age of 18.
- Participants should reside in Baton Rouge, Louisiana or the surrounding area.
- Participants should be a mother who has been medically diagnosed with depression during pregnancy and/or post pregnancy.
- Participants should be parenting at least one child under the age of 12.

Description of Study Procedures

About six to ten women over the age of 18 who have been diagnosed with peripartum onset will self-identify as having met the criteria to participate in this research study. Those women will take part in this study in Baton Rouge, Louisiana or around that area.

The estimated time commitment to participate in this study will take about 45 minutes to 1 hour in one contact. Participation in this study will not impact the receiving of services at a local mental health facility and the information you disclose will not be shared with any service providers. The following are some sample questions that are included in the research study.

- Could you tell me what age and/or when did your first experience with depression occur?
- When did you first notice you were feeling depressed?

Following the interview, research participants have the opportunity to review and make corrections to reflect accuracy of their responses from the interview. This includes asking participants to review and make corrections to reflect the transcribed copies of the interview, which will be emailed to participants for accuracy. At the conclusion of the research study, participants will be emailed a one-page summary of research results. Participants will have the opportunity to review their responses via email within 3 days following the interview to confirm that their responses are accurate. Participants should take about 15 minutes to review their responses. Additionally, a one – page summary of the research results will also be shared via email to community stakeholders.

Risks

There are no known risks for taking part in this study. However, revisiting the issue may cause someone to become upset.

Benefits

Your participation may benefit others that have experienced peripartum onset depression. Your participation in this study is needed.

Participation Is Voluntary

Participation is voluntary and the research participant can withdraw at any time. Not participating in the study will not involve any penalty or loss of benefits to which you are otherwise entitled. If withdrawal from this study is needed, do not hesitate to contact the Principal Investigator Shenetha Ramsey in regard to this matter via email at shenetha.ramsey@waldenu.edu.

The specific reasons for the investigator to remove research participants from the study occur if study procedures are not followed. If study procedures are not followed, the results of the study are invalid. Criteria that excludes participation includes, research participant is not over the age of 18, is not English-speaking, is a student, client, or employee of the researcher and participant, and participant is not parenting child(ren) under the age of 12. Women who are currently receiving treatment for depression will be excluded.

Confidentiality

If the results of this study are published, research participants will not be identified. A research participant's information may be disclosed if required by law. The research investigator will keep the records from the study for a minimum of five years, putting all data in a file organizer and placing all data in a secured filing cabinet. Although measures will be taken to maintain privacy, absolute confidentiality, such as, only having research participants complete demographic sheet only disclosing their first initial and last name.

This will help the Principal Investigator to obtain a brief description of each participant's demographics. Some entities may view or copy the study-related information. These entities include: The dissertation committee, who gives voice to the interests and needs of graduate students and faculty, and local, state and federal agencies as required by law. Please note that I am obligated as a mandated reporter by the state of Louisiana to report criminal activity or child abuse.

Compensation

Research participants receives a gift card for participating in the study.

Who Do You Contact for Questions About the Study?

If you have any questions about the study procedures, please contact the study Principal Investigator, Shenetha Ramsey via email at shenetha.ramsey@waldenu.edu or Research Committee Members, Dr. Pamela Denning at pamela.denning@mail.waldenu.edu and/or Dr. Scott Hershberger at scott.hershberger@mail.waldenu.edu.

The University's Research Participant Advocate can be contacted by participants if they have questions about their rights at the following: USA number 001-612-312-1210 or email address IRB@mail.waldenu.edu.

Statement of Consent Signatures

This study has been explained to me and my questions have been answered. I can call the study investigators, listed on page 1, with any further questions I may have. I have been given a copy of this consent form. I agree to take part in this study. I have not waived any of my legal rights by signing this form.

□ Check box if Research Participant received Resource List. Initials_____

Circle only one and write your initials:

Do you give me permission to voice record this interview? **Yes No Initials_____**

Write your month and year of birth to verify your age. _____

Printed Name of Participant

Signature of Research Participant Date of Consent

Email Address of Research Participant

Signature of Investigator Date of Acceptance

Appendix E: Resource List

The following contacts listed below are professional service providers listed on the Postpartum Support International (PSI) website; http://www.postpartum.net who are trained, certified and/or licensed to provide immediate assistance to anyone who may need any attention in case an emergency arises related to postpartum depression or if an immediate threat is disclosed.

Postpartum Support International (PSI) 1-(800)-944-4773

Louisiana State Coordinator
Misty M. Wainwright, LPC, NCC
1401 Ochsner Blvd Suite B
Covington, LA 70433
Phone: (985)-867-0803
Email: wainwrightpsi@hotmail.com

Police
911

National Suicide Prevention Hotline
1-(800)-273-8255
https://www.suicidepreventionlifeline.org

Louisiana State Coordinator
Joanne Harmon, RN, LPC
638 Sequin Street
New Orleans, Louisiana 70114
Phone: (504)-508-0570
Email: joanneharmonpsi@yahoo.com

Louisiana State Coordinator
Jessica Latin, MS, LPC
Shreveport, Louisiana
Phone: (318)-459-8683
Email: jessicalatinpsi@gmail.com

Lafayette Moms & Babies
1116 Coolidge Blvd. Ste C
Lafayette, Louisiana 70503
Phone: (337)-400-1815
Email: LafayetteMomsAndBabies@gmail.com

Tabitha Muse Carranza, MS, LPC
803 Coolidge Blvd Suite 107
Lafayette, Louisiana 70503
Office: (337)-806-5552

Email: carranzacounseling@outlook.com

To report suspected child abuse or neglect, call toll-free 1-855-4LA-KIDS (855-452-5437) to speak with a trained specialist 24 hours a day, 7 days a week.

Mandated Reporters of Child Abuse and Neglect

WHEN & HOW TO REPORT ABUSE/NEGLECT?

The Louisiana Children's Code (Article 610) specifies that mandated reporters shall make reports immediately upon learning of incidents of child abuse or neglect. When you have reason to believe a child may have been abused or neglected by a parent or caretaker, contact the Department of Children and Family Services (DCFS):

1-855-4LA-KIDS (855-452-5437)

Reports made orally must be followed by a written report to DCFS or local law enforcement within five days. A form (CPI-2) for this purpose is available at www.dcfs.la.gov/abuse.

If the child abuse or neglect is by someone other than a parent or caretaker, it shall be reported to the local law enforcement agency.

www.dcfs.la.gov/abuse

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DCFS Form CPI-P2, Issued: 12/12 Replaces: 07/08

SAMPLE

WHO ARE MANDATED REPORTERS?

Louisiana Children's Code Article 603 defines "mandatory reporter." They are any of the following individuals:

“Health Practitioner”:

Any individual who provides health care services, including a physician, surgeon, physical therapist, dentist, resident, intern, hospital staff member, podiatrist, chiropractor, licensed nurse, nursing aide, dental hygienist, any emergency medical technician, paramedic, optometrist, medical examiner, or coroner who diagnoses, examines, or treats a child or his family.

“Mental Health/Social Service Practitioner”:

Any individual who provides mental
health care or social services diagnosis, assessment, counseling, or treatment, including a psychiatrist, psychologist, marriage or family counselor, social worker, member of clergy, aide, or other individual who provides counseling services to a child or his family.

“Member of the Clergy”:

Any priest, rabbi, duly ordained clerical deacon or minister, Christian Science practitioner, or other similarly situated functionary of a religious organization unless not required to report a confidential communication as defined in the Code of Evidence Article 511.

“Teaching or Child Care Provider”:

Any person who provides or assists in the teaching, training and supervision of a child, including any public or private school teacher, teacher’s aide, instructional aide, school principal, school staff member,

bus driver, coach, professor, technical or vocational instructor, technical or vocational school staff member, college or university administrator, college or university staff member, social worker, probation officer, foster home parent, group home or other child care institution staff member, personnel of a residential home facilities, a licensed

or unlicensed day care provider, or any individual who provides such services to a child in a voluntary or professional capacity.

"Police Officers or Law Enforcement Officials"

"Commercial Film & Photographic Print Processor":

Any person who develops exposed photographic film into negatives, slides, or prints, or who makes prints from negatives or slides for compensation.

"Mediators":

Appointed pursuant to Children's Code, Chapter 6 of Title IV.

"Parenting Coordinators":

Appointed in a child custody case pursuant to R.S. 9:358.1.

"Court-Appointed Special Advocates (CASA)":

CASA volunteer under the supervision of a CASA program appointed pursuant to Chapter 4 of Title IV.

"Organizational or Youth Activity Provider":

Any person who provides organized activities for children, including administrators, employees, or volunteers of any day camp, summer camp, youth center, or youth recreation programs or any other organization that provides organized activities for children.

"Coaches":

School coaches, including but not limited to, public technical or vocational school, community college, college or university coaches and coaches of intramural or interscholastic athletics.

RELATED CRIMINAL CODE PROVISIONS

La. R.S. 14:403 mandates any person who is eighteen years of age or older who witnesses the sexual abuse of a child to

report the abuse to law enforcement or the Department of Children and Family Services as required by Children's Code Article 610.

La. R.S. 14:131.1 mandates any person having knowledge of the commission of any homicide, rape, or sexual abuse of a child to report such information to a law enforcement agency or district attorney, except when the person having such knowledge is bound by any privilege of confidentiality recognized by law.

WHAT IS ABUSE AND NEGLECT?

The Louisiana Children's Code provides the following definitions of abuse and neglect by a parent or caretaker:

"Caretaker" means any person legally obligated to provide or secure adequate care for a child, including a parent, tutor, guardian, legal custodian, foster home parent, an employee of a public or private day care center, an operator or employee of a registered family child day care home, or other person providing a residence for the child.

"Abuse" means any of the following acts which seriously endanger the physical, mental or emotional health and safety of the child.

- The infliction, attempted infliction, or as a result of inadequate supervision, the allowance of the infliction or attempted infliction of physical or mental injury upon the child by a parent or any other person.

Appendix G: Newspaper Ad

Sample Research Flier –Newspaper (Optional)

Note: This size ad may be a total cost of $581.10 for 30 days.
If IRB rejects the use of this ad, it will not be used.

This Ad to be placed in the Classified section of The Advocate newspaper in Baton Rouge, Louisiana and surrounding areas.

Doctoral Research
On Related Topic: Maternal Depression and Parenting Mothers

Have you? or Do you know any mothers who have experienced depression during pregnancy, within 4-6 weeks after giving birth and/or while parenting their child(ren) under the age of 12?

Recruitment criteria for a confidential interview: English-speaking mothers over the age of 18 who has the capability to provide permission to participate in a 45 minute to 1-hour interview, including the opportunity to ask questions and obtain answers related to the research study.

Benefits/Risks: Benefits of participating includes, the opportunity to share your lived experience with depression as a parenting mother as it relates to social support received. Risks may include recall of past negative memories.

Interview type: Private meeting/or via phone.