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Surviving Postpartum Depression and Choosing to be a Mother

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Abstract

Purpose: The primary study purpose was to describe the meaning of the lived experience of postpartum depression (PPD) for rural women.

Background: Many consider childbirth to be a normal life event. However, some new mothers experience postpartum depression (PPD) which interferes with the maternal infant relationship, infant development and spousal relationship. Few PPD studies have been conducted with rural women who disproportionately experience other health care problems such as depression due to high poverty levels and poor access to healthcare.

Design: A phenomenological approach was used to collect narrative data about women's experiences with PPD.

Methods: Open-ended audiotaped qualitative interviews were conducted with five rural white women who self-reported PPD. Qualitative analysis was conducted to identify study themes and overall pattern.

Findings: Themes included: No Idea It Would Happen To Me, Losing Myself, A Bad Place To Be, and Working Through. The overall pattern Choosing to be a

Mother encompassed those themes as women described the process of overcoming their PPD.

Conclusion: Further research is required to explore the phenomenon of postpartum depression especially with regard to the traumatic effects of birth, possible associations of PPD with Post Traumatic Stress Disorder, and how women make the choice to become a mother.

Keywords: Postpartum depression, women, rural, qualitative, phenomenological, birth, social support

Surviving Postpartum Depression and Choosing to be a Mother

For many women postpartum depression (PPD) continues to interrupt the socially expected experience of a joyful, effortless transition to motherhood. Approximately 10% to 19% of new mothers will experience PPD,[1,2] which interferes with the maternal infant relationship, infant development and spousal relationship.[3-7]

Postpartum depression in rural women has rarely been addressed. According to Galambos, rural populations in the United States face serious health disadvantages compared to urban populations.[8] Women in rural areas experience difficulties with poverty, access to care and quality of care when compared to women living in urban areas.[8] Depression and depressive symptoms disproportionately affect rural women.[9] Based on persistent health concerns in rural areas, including mental health problems, the National Rural Health Association (NRHA) has called for continued studies in rural areas to address disparities in care.[10,11] The NRHA has also called for more research to reflect how rural women's values and resilience affect positive health outcomes in some and not others.[12]

The NRHA defines rural based on the characteristics of the community in relationship to poverty, access to care and population.[12] The NRHA reports depression rates as high as 41% have been observed in rural communities compared to urban rates of 13 to 20 percent.[12] Such disparities may be related to underuse of health care services, the stigma associated with mental illness in rural communities, and the reluctance to access mental health services.[11] An additional barrier to service unique to rural areas is the lack of anonymity in rural communities.[12] The researchers found no qualitative studies which have specifically addressed PPD in rural women.

The purpose of this study was to describe the meaning of the lived experience of PPD for women in a rural setting. The results will be used to develop approaches to studying a larger sample of rural women, which we anticipate will contribute to better understanding the disorder in this population. A better understanding of the disorder will facilitate early identification of symptoms which can result in early

treatment and improved prognosis for the mother, infant, and family. Descriptive phenomenology was used to provide a method for insight into the phenomenon of PPD. Although the work did not test Beck's PPD theory, her theory informed this qualitative study.[4,5]

Background

Approximately 10% to 19% of new mothers will experience PPD.[1,2] A debilitating, under-diagnosed[13-15] mood disorder occurring within the first four weeks to one year following childbirth, PPD can have long term negative effects related to infant development, maternal attachment and spousal relationships for the new mother and her family.[4,13,16,17] In addition, the lack of interaction between depressed mothers and their newborns contributes to the development of depression later in the child's life.[13,18] The relationship between the woman with PPD and her spouse or partner may also be affected.[13,19]

Currently, the community and health care professionals are more cognizant of PPD because of media coverage.[20] However, women continue to remain reluctant to admit to feelings of inadequacy or antipathy toward their newborn, making diagnosis of PPD difficult.[21] Because women often feel overwhelmed, fatigued, guilty, and deprived of sleep during the postpartum period, and have little knowledge of PPD, they may not relate their symptoms of loneliness, sadness, and isolation to depression.[21,22] This may contribute to under-diagnosis of PPD.[14,19,23,24] Under-diagnosis and under-treatment may also be related to primary care providers lack of knowledge of, disagreement about whether PPD is depression or is a unique disorder, and lack of reporting due to the stigma related to PPD.[14,25-27]

Proposed Etiology and Treatment of PPD

Studies on the etiology of PPD have found no single causal factor for PPD; a variety of sociological, psychological, and physiological factors may influence PPD.[1,6,28,29] Study of biomedical factors such as changes in estrogen, progesterone, prolactin and thyroid hormone levels have not yielded definitive results.[28]

Treatment recommendations for PPD include medication and a combination of either cognitive behavior therapy or group therapy. However, these treatments are underused, at least partly because mothers have difficulty admitting a need for help.[20] Appleby suggested that the use of medication and counseling may be equally effective in the treatment of PPD, but that women were more reluctant to take medication than attend counseling sessions.[29] The reasons for this were unclear and decisions not to use medication for PPD have not been well explored.

Social Support as a Buffer

In general, social support has been shown to buffer individuals from the negative effects of stressful events.[30] Social support consists of receiving instrumental support, such as childcare, housekeeping, and emotional support, and also includes the proximity and frequency of a social network such as husband, partner, immediate family or friends.[30] Social support is a predictor of PPD with lower social support related to higher depression scores.[18,31,32]

A review by Beck supported findings from earlier studies, revealing four new predictors: self-esteem, marital status, socioeconomic status, and unplanned/unwanted pregnancy.[31] Women with higher education levels, full time jobs, and high incomes have lower depression and higher social support scores than women with less education, lower income, and no jobs.

Several other factors have been found to influence social support. Women with planned pregnancies have higher levels of social support than those with unplanned pregnancies.[18] Primiparas appear to have higher postpartum stress but also higher levels of social support than multiparas,[33] and women who breastfeed have higher levels of social support than women who bottlefeed.[18,34] Women with satisfying birth experiences have lower postpartum stress scores, lower depression scores, higher social support scores, and better levels of health.[33]

Kennedy, Beck & Driscoll suggest that use of supportive measures in the form of PPD education for family members, provides early intervention and detection of PPD which decreases the duration of illness and improves outcomes.[35] Understanding the perception of support by women experiencing PPD may contribute to improved outcomes and decreased symptom severity. Multidimensional supports such as spouse or partner, family, friends, and care providers can improve the detection, intervention and outcomes associated with PPD.[35]

Women's Voices Across Cultures

Research has addressed the experience of PPD among a variety of populations[38-40] including European American, African American and Chinese women examining the relationship between cultural factors and PPD. A qualitative study of twelve African American women focused specifically on experiences of PPD. Findings were similar to those of Beck's[38] study but with culturally specific themes such as Dealing With It, which suggested that women must adjust and move forward. Amankwaa[41] found that faith played an important role in survival. A subtheme, Keeping Secrets, appeared to be a similar to many women's idea that they cannot share their darkest moments with others because of the risk of being denounced as a bad mother.[41]

In addition, Amankwaa's research suggested that African American women may be more reluctant to report PPD, leading to inadequate diagnosis and

treatment.[40] Hung suggested that both physiological and role changes in the postpartum period may lead to increased stress among Chinese women, and that there is a similar relationship of maternal stress with depression, health status, partner relationships, and maternal attachment.[18]

Other cross-cultural studies have examined the concepts of unrealistic expectations and loss of control with a focus on cultural context.[27,39,42,43] Chinese women experienced a loss of control associated with PPD[39] and Chen et al. found Taiwanese women may undergo four stages of coping with the loss of control.[42] Swedish women with PPD experienced Struggling with Life, a theme suggesting loss of the women's previous role to a new mothering role, overwhelming responsibility for the new child, and feelings of abandonment.[13] Similarly, stories of Jordanian Australian women described themes of PPD related to loneliness, isolation, lack of social support, the overwhelming task of fulfilling traditional gender roles, and failure as a mother.[43] Other qualitative studies also suggest that coping behaviors may affect the severity or longevity of the disorder.[5,18,41,43]

A qualitative study by Lawler and Sinclair[44] studied a small sample of women in Ireland who described their experience with PPD as normal; after experiencing a Death of Self, they accepted their new role as a process of the transition to motherhood. The same theme of the experience of a death of one's former identity was also associated with Beck's original theory,[38] which supported a transcultural experience of PPD. This idea of normalcy in the transition from PPD to acceptance of motherhood has not been well explored.

Beck's review of qualitative studies related to PPD suggested that themes are similar across varying cultural contexts.[45] Overall review suggests that women are faced with a difficult task of trying to meet society's vision of the happy, uneventful transition to motherhood. Thus feelings of isolation, inadequacy, and failure as a mother contribute to depression, along with a sense of loss of one's old identity in the movement toward this new role as mother.[5] Beck's metasynthesis suggested that theoretical frameworks could be developed to guide clinicians in creating interventions to decrease the incidence of PPD.[5]

While there are similarities in the experience of PPD across cultures,[44] PPD has been observed more closely in urban women than in rural women. Although rural women in the United States are at higher risk for depression overall, the experience of women in rural populations has not been specifically addressed. Characteristics of rural communities indicate higher levels of stigma associated with mental health disorders and therefore greater reluctance to seek treatment.[12] In addition to lack of access to primary care and specialty care, the environment of small rural communities often means each woman's story is shared within the community. Thus seeking care is not a viable option. The NRHA[12] recommends further research in the area of women's mental health.

Thus the aim of this study was to hear the voices of women in the rural American South.

Method

A qualitative approach was used to examine the experience of PPD among women in a rural setting. Phenomenology was used because the topic has not been well explored and because phenomenology brings to language the perceptions of the human experience.[46]

Sample

The sample for this small study, done in preparation for a larger study, consisted of five white women ranging in age from 22 to 50 years old from the Southeastern United States. Four of the women were multiparas; one was a primipara. Three experienced PPD with the birth of the first child and two with the second child. The participants' children ranged from 21 years old to 14 months old at the time of the interviews. All participants self-reported PPD and lived in a rural area. All spoke and understood English, had health insurance, had a high school or college education and were married working outside the home.

Participants were recruited by professional and personal colleague referrals and from posters placed in two physicians' offices. IRB approval was obtained and participants completed informed consent. Each participant received an incentive of 25 dollars.

Data Collection

All interviews were completed in private settings agreeable to participant and researcher. Each interview began with the same set of questions and then continued based on participant responses. Interview questions were based on the literature and the researcher's experience, and were reviewed beforehand by nursing experts. Open ended questions such as: "Tell me about the baby's birth" and "How did you get through this period of PPD" were used to encourage participants to verbalize their experience. Clarifying questions were asked when further information was needed (See Appendix A). Demographic data were obtained at the end of the interview. Interviews were tape recorded and ranged from 45 to 60 minutes in length depending on how long participants wanted to talk. Because of a possible reluctance to share sensitive information in a group situation, interviews were conducted individually in a private location comfortable to the participant.

Each interview was transcribed verbatim by a transcriptionist from whom participants' identities were withheld. After each interview, the transcript was reviewed to correct mistakes and provide the basis for data analysis. Each participant was given a copy of her transcript and asked to contact the

researcher if she had further comments or clarification. No changes were made by participants. Data were de-identified and locked in a secure cabinet.

Analysis

Each transcript was printed in a different font color to keep transcripts recognizable without obstructing confidentiality. After reading each transcript and completing a summary of its overall meaning, it was examined line by line for themes and meanings and then by sentences, by paragraphs and by larger passages. Transcripts were reviewed by peer reviewers who were doctoral students and faculty with qualitative expertise. Major themes were those identified by the researcher and supported by peer reviewers. Themes were then categorized into groups of ideas that had similar meanings. Each piece of data was compared against all other pieces until all five transcripts were coded. Although saturation of data is a goal of qualitative research, it is likely in this small study that data saturation did not occur.

Results

The data include interview narratives, field notes, and perspectives from analysis of peers and qualitative experts. Quotes presented here are labeled with pseudonyms to protect participant's identities. Data analysis suggested four major themes: No Idea It Would Happen to Me, Losing Myself, A Bad Place to Be, and Working Through. The overall pattern of Choosing to be a Mother emerged at the end of analysis.

No Idea It Would Happen To Me

Each participant talked about pregnancy as a happy time, not anticipating any problems. The beginning for these women was one of happiness based on expectations of an enjoyable transition to motherhood. The women did not expect to experience problems during delivery or with the transition to motherhood. "It was a surprise from what I thought it would be" said Addie who felt fully prepared by childbirth classes and her friends' stories of childbirth and breastfeeding. Mary stated, "I already had one child…I guess I never thought it would happen to me." Addie noted, "Everybody has this picture of just this little dreamlike existence and it's not reality." Normalcy was the ideal and was what the women expected. Addie went on to say, "We had this nice little bundled up package…..I thought, "I could do this," …..and then nothing nowhere near close to that happened."

Another participant, Rebecca, commented: "We had fearless beginnings." She explained she and her husband were happy and all was normal until the baby was born. She experienced a traumatic delivery for which she was not prepared.

Losing Myself

All the women talked about feeling lost and as one participant, Resa said:

It was like I couldn't find myself; I had lost myself. I can remember that more than anything; standing there looking in the mirror and saying I don't know you, who are you?

The loss suggested a focus on the role change. Melanie delivered uneventfully but said that she felt unable to find herself, while describing her role transition to motherhood at home with her children. She appeared to welcome motherhood but described grieving that she could not continue, with proficiency, the active lifestyle of work and motherhood she had before childbirth.

Unhappiness was also a common thread associated with loss for the participants. Rebecca stated, "I don't think anything (during the postpartum period) represented happiness. I didn't feel happy about anything." Three of the participants spoke of considering suicide following the birth of their children. Unhappiness represented loss of ideal expectations, loss from not transitioning easily to a mothering role, feeling like a failure, and loss of support by family and friends. Melanie was a professional who remembered the experience of bringing home her newborn after a traumatic delivery with the newborn's resuscitation, a long stay in a neonatal intensive care unit (NICU), and coming home with a child with long-term needs. The baby did not have a heartbeat, was blue, and did not cry. Months were spent in the neonatal intensive care unit away from family and friends. Even after discharge from the NICU, the loss of support followed her home. Melanie said, "Some people just stayed away……people I expected didn't come around….so I felt like I didn't have anybody."

The mother of two children, Resa commented, "I felt inadequate at everything……so inadequate." Feelings of inadequacy created a sense of failure in taking on the new mothering role. Not expecting these feelings after a second pregnancy emphasized the idea that this mother had no idea it (PPD) would happen to her.

A Bad Place To Be

Addie described the postpartum period as a bad place and this theme embodied the conflicting emotions each of the participants described including: not being able tell anyone about their conflicting emotions, their overwhelming fatigue, their sense of understanding women in the media who have had the disorder, and thoughts about harming themselves or their babies.

Three of the participants described having conflicting emotions. Rebecca stated, "It's odd but the thing that's the greatest joy in life is also the greatest pain in your life," as she described her love for her newborn but the realization that a child with special needs would have lifelong physical disabilities. Not Being Able To Tell was part of the conflicting emotions experienced by the participants and as

Rebecca continued, “I never talked about the worst of it with anyone. Not until I was way out of it.” Because they didn’t feel that they could tell anyone how they felt, the women were also afraid to ask for assistance, and all the participants described their fear of consequences of disclosure, being considered mentally ill, and having others think they were unable to care for their children and at the same time wanting help. Several stated that they were afraid that they actually were mentally ill, and as Melanie stated: “I felt like I was losing my mind.” Addie described wanting to adopt out the baby but recognizing that would make her husband unhappy which she did not want to do.

Two women remembered their feelings of wanting to get away both physically and mentally, feeling overwhelmed by fatigue and exhaustion but being unable to escape. All the participants described this extreme fatigue. As Resa shared “..as time went on I just had this extreme fatigue….I just felt tired and I couldn’t go anymore.” She talked about fatigue lasting much longer than the normal six week postpartum period.

Several women talked explicitly about being afraid that if they sought help, or told anyone how depressed they were, they risked losing custody of their child and/or being thought of as a “bad” mother. A part of conflicting emotions was fear of losing custody while at the same time wishing that pregnancy, delivery and motherhood had never happened. Several noted that they now understood for the first time the experiences of women with PPD who had been in the news because they had harmed their children, and empathized with them. Rebecca quietly commented:

I think that is like the idea that you want to take control back of your life and then the thing about the lady in Texas who had killed her four children and I remember that was really scary, I knew, I understood how she felt and what she did. Because I mean I just knew she didn’t think she was harming her children, it’s the idea you are relieving them from suffering.

Working Through

The final theme from the interviews reflected the ways that the participants worked through their depression. Addie stated, “You just, you got to work your way through it.” She talked about bonding with her infant after weeks of feeling inadequate, and then of finding a way to have the feelings she expected initially by finding her own way of bonding. This didn’t occur immediately but three months into the postpartum period. Addie explained:

My way of bonding to this day, and I can remember sitting in that bedroom, the first few days and I would hold him against my chest and put his little hair and his little head against my mouth, and under my nose, I get that warm feeling you are supposed to have or that you hear your supposed to have, that’s where my bonding is.

Addie's grandmother was her salvation as the new mother visited her matriarch who provided direction, support and love in the Addie's struggle with her deep depression.

A young mother trying to survive a traumatic birth, Rebecca told the story of how after several weeks she stopped thinking of hurting her baby and of hurting herself, she promised her child she would be there for her, saying, "Then I just started promising her each morning that I would be there because regardless of what was happening with her……..I just knew that she knew that I was her mother and that's all that she knew." This young mother daily faced the future with a child who would require long term care related to a premature, traumatic birth. Navigating the pediatric specialist visits, arranging therapy sessions, and working through the transition to motherhood was an act of survival.

Resa, a successful professional provided an example of her struggle to work through and adjust to being both working professional and mother. As a young mother she attempted to manage her professional life and the new family life much as she had prior to the births of her children. The constant struggle to meet both the demands of work and motherhood and work through the depression left Resa feeling exhausted and feeling inadequate. Resa explained:

I think at some point I realized that I was not going to be able to do a job at work like I had normally done; I wasn't going to be able to do the quality work that I thought I needed to do plus be the mom I needed to be and I ended up feeling like I never could accomplish anything but then as time went on I felt more like I was being better as a mother but not as good as I should be at work.

Resa decided to make being a mother a priority but maintain her professional career which may appear to be a normal struggle for new mothers; but, in Resa's case, the struggle was validation of her inadequacy as a mother.

All participants voiced feelings of isolation from family and friends, and describe their perceptions that people did not provide the support they needed. One participant, Addie, talked about friends who had experienced some of the same emotions in their postpartum period but did not share those feelings with her until Addie told them about her depression. Rebecca and Melanie both felt unable to share their feelings with family or friends. Mary was asked by a health care professional if she had thoughts of killing her spouse and Resa was told she was just tired; thus, neither sought help from other care providers. The response of Resa's family to her fatigue and depression was to take her children so she could rest, when she actually needed a different kind of support. The women encountered the myth that such a transition was joyous and easy, implying failure on their part.

As demonstrated in Rebecca's story, there was a sense for all the women in this study that working through this process resulted in a decision that each woman

made in choosing to be a mother. A normal transition for most women occurring in the first few weeks postpartally, for these five women the transition was achieved over a time span of years. For each participant, the emotions associated with PPD were as vivid today as they were in the postpartum period spanning from months to years. After experiencing feelings of loss of self, inadequacies, and exhaustion, each woman at some point chose to become a mother, making a conscious choice to overcome the trauma of living with PPD.

Two participants experienced flashbacks, triggers, isolation and symptoms often associated with post-traumatic stress disorder (PTSD). These women experienced difficult births that had long-term physical effects for their infants. Melanie delivered prematurely and Rebecca's child was born without a heartbeat; both infants experienced vigorous resuscitation and long stays in the neonatal intensive care unit. It is only recently that difficult childbirth has been recognized as an event that can lead to the development of PTSD.[47] PTSD can result not only from difficult labor and birth but also from birth consequences, both maternal and infant.[4,48] Currently it is unclear as to whether PPD is an effect of PTSD or if the two disorders occur at the same time.[48] Further research investigating an association between PPD and PTSD is needed to understand the disorders in relationship to labor, delivery, and the postpartum period. The findings suggested strong emotions concerning the delivery and postpartum experience years after the occurrence.

Discussion

The study results indicated that, for these participants, the postpartum period was a journey from the unexpected through depression to survivorship. The themes described an emotional process experienced in the postpartum period, which led to the choice made by each to become a mother to her child. An innocent belief that PPD would not happen to them, loss of self, being in a bad place, and working through were attempts to create their own maternal role.

New mothers often have idealistic images of the transition to motherhood. The women in this study experienced a dramatic shift from what they imagined motherhood to be like to the reality of their experience. Their stories demonstrated the fact that as new mothers, even after previous births, they were unprepared for the realities of what is viewed as a natural, joyous event.

Each woman talked about the period of time before delivery when they experienced happiness and joy, followed by a period of sadness, denial, blame, stress, role change, and loss of control after the birth of the baby. The women were all well educated and had attended childbirth education classes, but were unprepared for the loss of their previous roles and for the problems caused by difficult birth experiences. Each described asking herself, "What did I do to cause this thing to happen?" None of the participants talked specifically about stigma related to their depression in the postpartum period but all talked about feeling

isolated, having loss, and being afraid to ask for help. In addition, we did not specifically address the importance of religion in their experiences and they did not bring it up.

Access to mental health providers in this rural community was problematic. Extended family, friends, and co-workers were underutilized as support systems due to the fear of being perceived as a bad mother. There is a gap in the research about PPD among women living in rural areas. The experience of women in this study was similar to those in previous urban studies. However, these women matured to womanhood in rural communities developing strong beliefs about mental illness as a weakness, having poor access to mental health services, and incorporating a community focus on the norms associated with pregnancy, birth, and delivery. These women were Caucasian, well educated, and had strong support systems. However in spite of their economic and social advantages, they still felt the stigma of mental health problems that disproportionately affect rural dwellers. Thus their experience was affected by their rural context.

Further research may be implemented to support the themes of “No Idea It Would Happen to Me”, Losing Yourself”, “A Bad Place To Be”, and “Working Through” as this process was based on a small sample of five participants who were demographically homogenous. The mothers in this study described the choice to become mothers within the first 6 weeks to 4 months following delivery. Infant development and maternal attachment may be interrupted by the event of PPD and PTSD with long term negative effects.[4,48] Investigation into determining which mothers attach and which mothers do not may reveal information to help healthcare providers implement interventions to recognize the risk for PTSD and PPD. Early recognition can foster early treatment to prevent or assist mothers in surviving such events.

Conclusion

The stories of these women demonstrate that they had inadequate support in coping with their PPD. The themes that emerged, No Idea It Would Happen To Me, A Bad Place To Be, Losing Myself, and Working Through, demonstrate the isolation, loneliness and fear they experienced. These women did not have access to mental health treatment options and sought help from family and friends before involving a healthcare provider, if at all, which is characteristic of rural populations. Future studies of more diverse samples of rural women are needed to explore these possibilities.

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Appendix A:

List of Questions for Research Interview

Can you tell me about the time around the birth of your baby?
What concerned you most about yourself during this time?
What or who helped you the most?

What or who helped you the least?
Did you have any warning signs this would happen before the baby was born?
Were there any specific thoughts, behaviors, feelings, or actions that you would be willing to share with me?

Thank you for asking these questions. Is there anything else you would like to add?