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# Missouri Ozark Women's Experiences of Living with Postpartum Depression Symptoms

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**Missouri Ozark Women's Experiences of Living with Postpartum Depression**

**Symptoms**

**By**

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**College of Nursing**

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**In partial fulfillment of requirements for the degree of**

**Doctor of Philosophy in Nursing**

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**Ruth L. Jenkins, PhD, RN**

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## Abstract

Depression is a serious complication of the postpartum period that affects not only women but their children and families as well. Rural women are of particular concern because of the significant barriers to health care that they experience as a result of isolation, poverty, traditional beliefs, and a lack of accessible and adequate health related services. A review of the literature to identify evidence based nursing interventions that focused on primary and secondary prevention of postpartum depression revealed few interventions and there were no studies identified that targeted or even included women living in rural areas of the United States.

The purpose of this study was to gain an understanding of postpartum depression symptoms as they are experienced by women living in a rural area of the Missouri Ozarks. Gadamerian hermeneutic phenomenology was the framework that guided this study. Women were eligible for inclusion in the study if they self-identified as experiencing at least two symptoms of depression after the birth of their infant. Ten women between two and eight months postpartum participated in the study. Data were collected through a series of three face to face interviews with the study participants. Transcripts of the interviews were analyzed using thematic analysis. Seven themes were identified: Overwhelmed and Stressed, Loss, Financial Concerns, Abandoned and Alone, Stuck Here, Fiercely Responsible, and Hopes and Dreams. The findings of this study provide a beginning understanding of rural women's experiences of living with postpartum depression symptoms. These findings offer clinicians and researchers a different view of the phenomenon that can be useful in the identification of postpartum depression symptoms as well as the development of interventions directed at primary and

secondary prevention of postpartum depression in this population. The study also provides some insights into gaining and maintaining access to rural and underserved populations.

## CHAPTER 1: INTRODUCTION

### Background

Depression is a serious complication of the postpartum period that affects approximately 13% or about 500,000 childbearing women in the United States annually (O'Hara & Swain, 1996). Some studies suggest the actual rates may be even higher because of the number of cases that remain unrecognized (Hearn et al., 1998; Ramsay, 1993). While these rates do not differ significantly from the rates of depression found in women during non-childbearing periods, the potential consequences for women and their infants make postpartum depression a matter of considerable concern (O'Hara, 1994; O'Hara & Swain, 1996). Because postpartum depression occurs at a critical period, it threatens the health and well being of women, their children, and their partners (Goodman, 2004b; Horowitz et al., 2001; Logsdon, Wisner, Pinto-Foltz, 2006; Murray & Cooper 1996, 1997; McLearn, Minkovitz, Strobino, Marks & Hou, 2006; Murray, et al. 1999; O'Hara, 1995; Paulson, Dauber, Leiferman, 2006). Mothers who are depressed during the child's first year of life have been found to have fewer positive child health and safety behaviors than their non depressed counterparts and their children are at risk for social and cognitive delays as well as for abuse and neglect (Lesser, Anderson, Koniak-Griffin, 1998; McLean et al., 2006; Murray & Cooper, 1997; Murray et al., 1999; Paulson, Dauber, Leiferman, 2006).

Postpartum depression is a particular concern in rural populations where the detection, diagnosis, and treatment of all depressions are among some of the greatest health care challenges (Badger, Robinson, & Farley 1999). Women living in rural communities experience significant barriers to healthcare as a result of the isolation, lack



of transportation, and distance to health care services (Bennett, 2002). Many rural women are uninsured or underinsured and those who do have private or state medical insurance often have limited access to medical care because of a general shortage of physicians and nurses and an even greater shortage of mental health and reproductive health specialists (Bennett, 2002; Rabinowitz & Paynter, 2002). In addition to these challenges there is hesitancy by many to utilize those mental health services that are available because of legitimate concerns about confidentiality, the stigma attached to mental health issues, and the sense of rugged individualism that is common among many rural residents (Bennett, 2002; Blumenthal & Kagen, 2002; Rabinowitz & Paynter, 2002).

#### Contextual Description of the Phenomenon

Postpartum depression has been a phenomenon of interest over the last two decades but there remains a lack of consensus regarding etiology, symptoms, diagnosis, and treatment as well as a conceptual definition (Beck & Indman, 2005; Oats et al., 2004; O'Hara, 1997; Ugarriza, 2002). In addition to women who meet the clinical criteria for depression there are many more who have depressive symptoms that are troubling to both them and their families but do not meet the diagnostic criteria. Within the health care community there continues to be a lack of agreement about whether postpartum depression is basically the same as depression at other times in a woman's life (Evans, Heron, Francomb, Oke, & Golding, 2001; O'Hara, 1995) or a phenomenon that is qualitatively different (Beck 1992, 1993, 1996; Beck & Gable, 2000; Beck & Indman, 2005; Oats et al., 2004; Ugarriza, 2002). The symptoms that are reported by women with postpartum depression differ in some ways from those found in the *Diagnostic and*

*Statistical Manual of Mental Disorders IV-TR* (American Psychiatric Association, 2000) and need to be evaluated within the framework of changes that are normally anticipated as part of the postpartum process and adaptation to the maternal role (Beck & Gable, 2001a; Cox, Holden & Sagovsky, 1987; Horowitz & Goodman, 2005; Ross, Gilbert, Evans, Sellers & Romach, 2003b).

Women living in some of the most rural areas of the United States can be considered among this country's vulnerable populations because of the lack of social, environmental, and health care resources that exist in those communities (Leight, 2003). Rural women tend to marry younger, have less education, fewer job opportunities, lower income, and more children than their urban counterparts (Bennett, 2002). Depression, in general, is a major concern in rural areas where there are often few or no mental health specialists. Additionally, rural residents are often burdened with having to seek care outside their community and among strangers, experience long waits for the few services that are available, and find reliable and affordable transportation and child care (Badger, Robinson, & Farley, 1999; Guttman, Dick, & To, 2004). These factors place rural women at an increased risk for undetected and untreated depression during the postpartum period and the resulting long-term consequences for women and their families in a population that is already at risk for negative health outcomes (Amankwaa, 2003; Badger, Robinson, & Farley, 1999; Evans et al., 2001; Hudson, Elek, & Campbell-Grossman, 2000; Letvak, 2002; Murray & Cooper 1996; Murray, et al., 1999).

#### Justification for Studying the Problem

Postpartum depression is framed differently within different disciplines and this framing is influenced by the educational and practice paradigms of each discipline as

well as by the cultural and historical context in which PPD is studied. Health care professionals in general and physicians in particular frame PPD in a positivist tradition and, as such, put an emphasis on diagnosis and treatment. In the medical tradition it is primarily only those women who have been identified during pregnancy or postpartum as being at risk for developing PPD who are targeted and included in prevention studies and only those women who meet the diagnostic criteria of PPD who are included in intervention studies. This practice limits prevention and diagnostic opportunities for women and limits the development of new treatment approaches that may be helpful in the prevention of PPD for all women regardless of the presence of risk factors. The realities that are part of the world inhabited by a new mother can precipitate symptoms of depression in women who are not identified as being at risk or who do not meet the diagnostic criteria of PPD. A different understanding of PPD that allows clinicians to focus on prevention efforts for all postpartum women may necessitate a re-framing or re-conceptualization of the problem and consideration of the phenomenon within the context of society, history, culture, economics, and politics.

Recent studies of women in countries throughout the world have found postpartum depression to be a universal phenomenon that exists across countries, cultures, and ethnic groups (Haung & Mathers, 2001; Horowitz, Chang, Das, & Hayes, 2001; Oats et al., 2004). Women universally recognize a state of unhappiness that can occur in the weeks or months after delivery but they do not universally consider this state of unhappiness to be an illness or an event requiring the intervention of health professionals (Oats et al., 2004). Women's interpretations of their experiences of PPD vary and are framed by the context in which they are experienced (Horowitz, Chang et

al., 2001; Oats et al., 2004). No studies have been identified in the literature that examined the experience of postpartum depression in rural populations in the United States. Most of the qualitative studies of postpartum depression, including Beck's seminal qualitative works (Beck, 1992, 1993) on which most of the nursing theory of PPD is based, included only a small sample of almost exclusively urban, Caucasian, middle-class, well educated, married women. Until more is known about how rural women experience postpartum depression it will remain difficult to recognize the phenomenon as well as to design and test prevention and treatment interventions.

#### Relevance to Nursing

The prevention of PPD as well as the identification, referral, and treatment of women experiencing symptoms of PPD are important in the area of maternal-child or family health nursing. In the past and continuing into the present this has not been accomplished effectively (Hearn et al., 1998; Horowitz & Cousins, 2006; Zelkowitz & Milet, 2001). The problems of recognizing and treating depression are often exacerbated in rural communities because of the scarcity of family health practitioners and an almost complete lack of reproductive and mental health care providers. The rural counties of the Missouri Ozarks included in this study are no exception. In the counties targeted for this study there are few physicians, one to three nurse practitioners per county, and no obstetricians or pediatricians with the exception of two counties that have an obstetrician a couple of days a week. Mental health care is also limited with zero to five licensed counselors per county and most of these counselors work almost exclusively with children. There is a regional family counseling center approximately an hour to an hour and a half away in a neighboring county. The most available and consistent health care

provider that new mothers see is the nurse at the county health center and the nutritionist at the WIC clinics. Approximately 75% of the women in these counties attend WIC clinics regularly and approximately 80% keep their infant's immunizations current during the first year of life predominately through the county health centers (Missouri Department of Health and Senior Services, 2005).

Nurses are in an ideal place to make a positive impact on the course of PPD among women living in rural areas. Simple screening questions or measurement tools can be used by nurses to identify women who may be at risk of PPD or in need of referrals or follow-up. The nurses at the health centers may be the only health care professionals that women living in rural areas are likely to see on a regular basis during the first year of their child's life. Many rural women have no health insurance so it is only within the context of health care for their children that they have an opportunity to interact with health care professionals. With a greater understanding of rural women's experiences of PPD nurses will be in a better position to identify women who are at risk or who are living with symptoms of PPD and to assist them with the identification of appropriate prevention and treatment resources.

#### Purpose of the Study

The purpose of this study is to gain an understanding of postpartum depression symptoms as they are experienced by women living in a rural area of the Missouri Ozarks. Women in this study will be asked to describe what life or the experience of being a new mother has been like for them since their baby was born or, if the depression symptoms started during pregnancy, what it has been like since that time. The specific aims of this study are to:

1. reveal the meaning of living with postpartum depression symptoms for women living in some of the most rural counties of the Missouri Ozarks and
2. give voice to women living in rural areas who are marginalized as a result of poverty and social and geographic isolation.

### Evolution of the Study

This study began as a quantitative proposal to test an intervention for antepartum and postpartum women in a rural environment. The purpose was the primary and secondary prevention of postpartum depression and the adverse effects it might have on maternal-infant interactions. An extensive review of current literature followed by a more focused systematic review of the literature was conducted. In the initial review of the published literature, MEDLINE, Cumulative Index of Nursing and Allied Health Literature (CINAHL), PsycINFO, and SocioFile were searched to identify studies related to postpartum depression or postpartum depressive symptoms as a means of identifying current knowledge about the phenomenon of postpartum depression in rural women. A search of the literature published from January 1999 through December 2004 resulted in the identification of 644 English language studies. No studies were identified that targeted women living in rural areas of the United States. An updated search through December 2006 failed to identify any studies of postpartum depression in women living in rural areas of the United States.

This initial review was followed by a systematic review of current literature. A systematic literature review is an appropriate means of gathering data that can be used to inform and guide clinical practice and research. It affords the researcher an opportunity to examine studies for findings that can be generalized as well as to detect inconsistencies in

the studies and discover areas in need of additional exploration or clarification. The purpose of this systematic review was to identify interventions that fit within the scope of nursing practice and had the potential to be health promoting for families through primary or secondary prevention of postpartum depression. Eleven clinical trials and four systematic literature reviews were found that met the criteria for inclusion in the systematic review. The antenatal studies failed to detect significantly lower depression scores in the intervention groups as compared to the control groups (Brugha et al., 2000; Hayes, Muller, & Bradley, 2001; Webster et al., 2003). The postpartum studies found lower post-intervention measures of PPD in the intervention groups as compared to the control groups and the differences were statistically significant in all of the studies (Armstrong & Evans, 2003; Armstrong, Frasier, Dadds, & Morris, 2000; Chabrol et al., 2002; Chen, Tseng, Chou, & Wang, 2000; Cooper, Murray, Wilson, & Romaniuk, 2003; Dennis, 2003; Heh & Fu, 2003; Wiggins et al., 2005).

The interventions varied in type as well as timing, different cut-off scores were used for inclusion criteria, screening for inclusion was done at wide variety of times, and the end points of the studies varied greatly. The sample size was relatively small in most of the studies and only three of the studies reported using power analysis to calculate sample size. These issues made it difficult to draw statistical inferences from this group of studies. There was no strong evidence in any of the four systematic literature reviews included in this review to support the effectiveness of any of the interventions (Austin, 2003; Dennis, 2005; Gamble, Creedy, Webster, & Moyle, 2002; Lumley & Austin 2001). The diversity of interventions and the broad range of end points signal caution when interpreting the collective data in these studies.

Finally, the Cumulative Index of Nursing and Allied Health Literature were searched to identify qualitative studies of postpartum depression. A search of the literature published from January 1990 through December 2006 did not reveal any studies that identified their population as rural. One study recruited participants from what they identified as a “large town,” a “small town,” and a “rural area” (Thurtle, 2003, p. 261). There was no indication of how many of the 14 participants were from the rural area and there was no description of the area other than to state that all of the women in the study were from a “relatively socially stable area” (Thurtle, 2003, p. 262).

The findings of these literature searches raise the question of whether researchers are listening to the women who are experiencing postpartum depression or postpartum depression symptoms. Professionals may be spending too much time and effort attempting to find solutions rather than asking the questions needed to understand the problem from the women’s perspectives (Lloyd & Hawe, 2003). There is a need to know considerably more about postpartum depression in general and postpartum depression in rural populations in particular before meaningful interventions can be designed and tested. Among the questions that remain unanswered are: have researchers asked the appropriate questions and listened skillfully to the answers as a means of gathering the information needed to design and test interventions that are meaningful; do researchers understand the experience of living with symptoms of postpartum depression; is the experience of living with symptoms of postpartum depression the same in rural populations as it is in urban populations?

As a result of these literature searches and reviews it was concluded that not only was there not enough known about postpartum depression in rural women but there was



not enough known about the prevention or non-chemical treatment of postpartum depression in any population to adequately inform the development of an intervention study. The most meaningful and appropriate action for researchers to do at this moment in time is to step back, ask the questions, and listen skillfully to the responses as a means of gaining an understanding of the symptoms of postpartum depression as they are experienced by new mothers. This will provide direction for the design of prevention and treatment interventions that are meaningful and have the promise of being successful. In view of these considerations, hermeneutic phenomenology was chosen as the most appropriate methodology to guide this study which aims to reveal the meaning of living with postpartum depression symptoms for women living in some of the most rural counties of the Missouri Ozarks.

#### Justification of Method and Methodology

It is the research questions that result from literature searches and clinical practice that should drive the research and determine the methodology to be used. It is where the researcher is ontologically and epistemologically situated that influences research choices. Because there have been no studies identified in the literature that examine the experience of postpartum depression or postpartum depression symptoms (PPDS) in rural populations the study of postpartum depression in women living in a very rural area should begin with qualitative inquiry. The researcher must first come to know the world as it is experienced by those in the population of interest and to understand the many facets of the problem before attempts are made to solve it. To begin with a randomized clinical trial to test an intervention to prevent or decrease the incidence and severity of postpartum depression prior to understanding the phenomenon within a cultural context is

to develop an intervention grounded in the life-world of the researcher rather than that of the participants or the knowers (Munhall, 2001). There are many studies that have examined PPD and PPDS. What is lacking is a description or understanding of the phenomenon through shared language that will provide a way of understanding the meaning of living with postpartum depression symptoms for rural women. This is a first step in designing an intervention with the potential to prevent or limit PPD or PPDS in a population of women living in rural areas. The manifestations of symptoms and the language used to describe them may be different in rural cultures as compared to more urban cultures making it difficult to screen for and measure PPD or PPDS in this population. Because not all individuals have the same cultural and social background the researcher must be open to the possibility that not everyone will interpret the spoken language used in describing an experience or phenomenon in the same way (Benner, 1994).

#### Preexisting Beliefs and Understandings

In qualitative works it is essential for the researcher to name personal biases prior to undertaking the study. It is only through identifying preexisting beliefs about the phenomenon being studied that there can be a true openness to the phenomenon as it reveals itself (Munhall, 1994; van Manen, 1990). The researcher must assume an attitude of openness to be able to discover what a particular experience or phenomenon means to the one experiencing it (Boyd, 2001; Gadamer, 1960/1989; Heidegger, 1996; Koch, 1996). In keeping with this tradition the researcher's preexisting beliefs are included in this chapter.

*Preexisting Beliefs*

- There are women living in the rural counties of the Missouri Ozarks who experience postpartum depression symptoms.
- Some women are not aware that they are experiencing PPD or PPDS or cannot name it.
- Women experiencing PPD or PPDS may not seek medical attention because they are not aware that they are experiencing anything unusual or that there is help available to decrease their symptoms.
- The experience of PPD or PPDS has the potential to interfere with women's abilities to interact positively with their infants.
- Both PPD and PPDS can have negative consequences for women and their families.
- Both PPD and PPDS can have negative consequences that threaten the well being of the entire family.
- Women, if unimpaired by depression or other negative forces occurring during childbearing and childrearing periods, take delight in their children and will go to almost any ends to protect them from negative influences in their environment.
- Humans construct the meaning of an experience and understand the experience from their own individual human perspective.
- Human realities do not exist independent of the world but, rather, interact with the world.
- The differences between general depression and postpartum depression are more than a matter of the time frame in which they occur.

### Orienting Definitions

- Postpartum depression – According to the American Psychiatric Association (2000), postpartum depression is a major depressive episode with an onset within four weeks of delivery. To meet the diagnostic criteria for a major depressive mood episode there must be the presence of a depressed mood and/or a decreased interest or pleasure in activities that were previously enjoyed. In addition to one or both of these symptoms there must also be at least four additional symptoms (three or more if both depressed mood and anhedonia are experienced) present for a period of at least two weeks. These symptoms, as listed in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000), include weight loss or weight gain, sleep disturbances, psychomotor disturbances, fatigue, feelings of worthlessness or excessive guilt, difficulty concentrating, and thoughts of death or of harming oneself.
- Postpartum depression symptoms – For the purposes of this study, postpartum depression symptoms will be defined as a mother’s experience of any of the following symptoms during the first year after delivery. These symptoms include: sleep disturbances, eating disturbances, anxiety, feelings of being overwhelmed or inadequate for the task of mothering, feeling all alone, emotional lability (including crying, anger, and irritability), loss of self or of what is “normal”, difficulty concentrating or focusing, guilt or shame, irrational thoughts, or thoughts of harming self.

- Rural – According to the United States Census Bureau areas of open country with settlements of less than 2,500 inhabitants are designated as rural.
- Most Rural – For the purposes of this study most rural refers to those counties that are designated as a “9” on the 2003 Rural-Urban Continuum code (United States Department of Agriculture Economic Research Service, 2003). These are counties that are completely rural or have settlements of less than 2,500 residents and are not adjacent to any metro area (United States Department of Agriculture Economic Research Service, 2004).
- Rural Ozark Women - Women living in any of the counties in the Missouri Ozarks that are designated as a “9” on the 2003 Rural-Urban Continuum code.
- Culture – for the purposes of this study, culture is defined as the traditional values, beliefs, practices, habits, likes, dislikes, norms, language, and customs that have been learned or socially inherited and shared by people living in families and communities (Spector, 2004).

## CHAPTER 2: REVIEW OF LITERATURE

### Postpartum Depression

Postpartum depression (PPD) is a non-psychotic depressive episode that begins or extends into the postpartum period (Gavin, Gaynes, Lohr, Meltzer-Brody, Gartleher, & Swenson, 2005; Joseffson, Berg, Nordin, & Sydsjo, 2001; O'Hara, 1995). Studies have found the incidence of postpartum depression (PPD) in the United States (U.S.) to be approximately 13% (O'Hara & Swain, 1995; Wisner, Parry, & Piontek, 2002). Current research, however, remains fraught with measurement problems (Beck & Gable, 2001a) and PPD remains a poorly understood and under-diagnosed sequelae of childbirth (Ugarriza, 2002; Wisner, Perry, & Pinotek, 2002). It is estimated that as many as half of the cases of PPD in the U.S. remain unreported (Beck, 2001; Hearn et al., 1998; Ramsay, 1993) which is due, in part, to a lack of agreement on a conceptual definition of PPD (Beck, 1998; Ugarriza, 2002).

The etiology of PPD remains unclear at this time. There are a number of factors that are believed to contribute to its development but no single cause has been identified. One theory is that the rapid decline of reproductive hormone levels after delivery contributes to the onset of PPD in some women (Wisner, Parry, & Piontek, 2002). Stressful life events, marital relationship, pregnancy and delivery complications, financial resources, social supports, and a personal or family history of psychopathology, particularly mood disorders, have been found to be among the factors believed to contribute to the development of postpartum depression (O'Hara & Swain, 1996; Rich-Edwards, et al., 2005; Wisner, Parry, & Piontek, 2002). There is no strong evidence that the risk of a non-psychotic depressive episode is significantly greater perinatally than at

any other time in a woman's life but the negative consequences for a woman, her infant, and her entire family make primary and secondary treatment of PPD a serious concern (Gavin et al., 2005; O'Hara & Swain, 1996).

The American Psychiatric Association (2000) describes postpartum depression as a non-psychotic depressive episode with an onset within the first four weeks after delivery. It is only the timing and not the phenomenon that distinguishes PPD from other major depressive episodes according to the DSM-IV-TR (American Psychiatric Association, 2000). There are, however, women who do not meet the DSM-IV-TR criteria for depression but who are experiencing symptoms of postpartum depression (Beck & Gable, 2000, 2001a). Some of these women will be identified through the use of a variety of screening tools, some will self-report that they are experiencing PPD, and others will experience postpartum depression that remains unrecognized by themselves, their families, or health care professionals. Still other women who are experiencing symptoms of postpartum depression will intentionally go to great lengths to hide their depression from family, friends, and professionals because of the guilt and stigma attached to depression (Beck & Gable, 2000, 2001a).

In contrast to the symptoms listed in the DSM-IV-TR many women with postpartum depression do not describe their primary symptom as a depressed mood (Beck & Gable, 2000; Beck & Indman, 2005; Oats et al., 2004) and their symptoms do not always appear as early as the first four weeks postpartum (Beck & Indman, 2005; Horowitz & Goodman, 2004; Miller, 2002; Zelkowitz & Milet, 2001). For many women anxiety or irritability may be the most noteworthy characteristic of postpartum depression

(Beck & Gable, 2000; Beck & Indman, 2005; Ross, Gilbert Evans, Sellers & Romach, 2003a).

A review of the literature on PPD found that women with postpartum depression described experiencing: anxiety (Beck & Gable, 2001a; Horowitz et al., 2001; Ross, Gilbert Evans, Sellers, & Romach, 2003a); irritability (Beck & Gable, 2000; Beck & Indman, 2005; Heh & Fu, 2003; Ross, Gilbert Evans, Sellers, & Romach, 2003a); fatigue or exhaustion (Heh & Fu, 2003; Horowitz et al., 2001; Ugarriza, 2002); sleep disturbances (Beck & Gable, 2000; Heh & Fu, 2003; Miller, 2002; Ugarriza, 2002); appetite disturbances (Beck & Gable, 2000; Miller, 2002; Ugarriza, 2002); feelings of being overwhelmed or inadequate for the task of mothering (Beck & Gable, 2000; Horowitz et al., 2001; Ugarriza, 2002); sadness or the absence of joyful feelings (Beck, 2001; Beck & Gable, 2000, 2001a; O'Hara, 1995; Ugarriza, 2002); guilt or shame (Beck & Gable, 2000, 2001; Ugarriza, 2002); despair or a sense of never getting better (Beck & Gable, 2001; Horowitz et al., 2001; Ugarriza, 2002); irrational or obsessive thinking (Beck & Gable, 2000, 2001; Horowitz et al., 2001); and thoughts of harming self (Beck & Gable, 2001; Miller, 2002; Ugarriza, 2002). Feeling irritable, anxious, overwhelmed, and alone were among the most commonly reported feelings and thoughts of harming self were the least reported (Beck & Gable, 2000; Beck & Indman, 2005; Ross, Gilbert Evans, Sellers, Romach, 2003a; Ross Gilbert Evans, Sellers, Romach, 2003b).

The literature also revealed a considerable amount of diversity in the methods used to diagnose and measure PPD. Some researchers and clinicians used measures of general depression such as the Beck Depression Inventory (BDI) (O'Hara, Stuart, Gorman, & Wenzel, 2000; Spinelli & Endicott, 2003), Center for Epidemiological



Studies Depression Scale (CESD) (Koniak-Griffin, Walker, & de Traversay, 1996; Lindgren, 2001; Logsdon & Usui, 2001; Pigeon, Seguin, Goulet, & Descarries, 2001), Hamilton Depression Rating Scale (HDRS) (Chabrol et al., 2002), Profile of Mood States (POMS) (Hayes, Muller, & Bradley, 2001), and clinical interviews using the criteria found in the DSM-IV and the International Classification of Diseases (ICD-10) (Brugha, et al., 2002). Other researchers and clinicians have used measurement tools designed and validated specifically for the measurement of PPD. These include the Edinburgh Postnatal Depression Scale (EPDS) (Beck & Gable, 2000; Chabrol, et al., 2002; Evans, et al., 2001; Heh & Fu, 2003; & Horowitz et al., 2001) or the more recently developed Postpartum Depression Screening Scale (PDSS) by Beck & Gable (2000; 2001a; 2001b). Many studies have used a combination of measures.

The temporal dimension of postpartum depression also differed among studies. O'Hara and Swain (1996) who have studied postpartum depression extensively, as well as others, describe the phenomenon as a non-psychotic depressive episode that begins or extends into the postpartum period (Evans et al, 2001). There are studies that have found the rates of depression to be highest late in pregnancy and up to the first eight to twelve weeks postpartum (Evans et al., 2001; Joseffson, Berg, Nordin & Sydsjo, 2001; O'Hara, 1995; Spinelli & Endicott, 2003) while others have conceptualized PPD as a depressive episode that begins during the postpartum period (Ferguson, Jamieson, & Lindsay, 2002; Miller, 2002; Morris-Rush, Freda, & Bernstein, 2003; Wisner, Parry, & Piontek, 2002; Ugarriza, 2002). For those who conceptualized postpartum depression as having an onset during the postpartum period, the time of onset varied from two weeks (Morris-Rush, Freda, & Bernstein, 2003) to six months (Miller, 2002). Some studies found a

spontaneous resolution of symptoms by 8-12 weeks for many women (Evans, et al.; Heh & Fu, 2003). A study by Zelkowitz & Milet (2001) found some women still symptomatic at six months postpartum and a longitudinal study by Horowitz and Goodman (2004) found 30.6% of the women who were diagnosed with PPD at 2-3 months postpartum were still symptomatic two years after delivery.

It is clear from the literature that clinicians, researchers, and women themselves do not concur on a common description of PPD but most do agree that the symptoms of postpartum depression are troubling for women and their families and that early detection and treatment are important in the promotion of the health and well being of mothers and their children (Beck, 2001; Beck & Gable, 2000; 2001a, 2001b; Chabrol et. al., 2002; Field, 1998; Miller, 2002; Murray & Cooper, 1997; O'Hara, 1995; O'Hare & Swain, 1996; Ugazzia, 2002). When early interactions between a mother and her infant do not take place, the infant's resulting lack of attention and interactions can be misinterpreted as incompetence by a woman who is already experiencing feelings of guilt and concern about her abilities to adequately care for her infant (Beck, 1996b; Papousek & Papousek, 1997). Qualitative and quantitative studies have found guilt and inadequacy to be among the feelings commonly expressed by women with postpartum depression (Beck 1993; Beck & Gable 2000; Horowitz et al., 2001; Ugarriza, 2002). Infant behaviors that evoke these feelings in new mothers can intensify their depressive symptoms.

Studies have found that not only does early communication strengthen bonding, but it is the means by which the didactic interactions needed to guide the development of cognitive abilities in the infant occur (Papousek & Papousek, 1997). The diminished maternal-infant interactions associated with postpartum depression in the early months of

a child's life can have long-term consequences for the social and behavioral development of these children even years after the maternal postpartum depression has resolved (Field, Morrow, & Adelstein., 1993; Murray, & Cooper, 1999; Murray et al., 1999; O'Hara, 1995; Stein et al. 1991). These behavioral consequences are not limited to the interactions that occur between mothers and their children but may also extend to other interactions including peer interactions in school settings. Researchers studying five-year olds whose mothers' experienced postpartum depression discovered patterns of play in school settings that were different in these children as compared to children whose mothers had not experienced postpartum depression (Murray et al. 1999). These initial disturbances in maternal-infant interactions are believed to set up a cycle that places children at increased risk for social and cognitive delays as well as for abuse and neglect (O'Hara & Swain, 1996; Murray & Cooper, 1997; Lesser, Anderson, & Koniak-Griffin, 1998; Leitch, 1999).

A study by McLearn et al. (2006) found that women with postpartum depression were less likely to have positive parenting practices than their non-depressed counterparts. These parenting practices included those related to child development, safety, and discipline. There is also evidence to suggest that the children of women with postpartum depression are less likely to receive age appropriate health maintenance visits and immunizations and more likely to be seen in the emergency department during the first three years of life (Minkovitz et al., 2005).

In addition to the effects of postpartum depression on women and their children, the findings of recent studies suggest that the negative effects extend to the partners of women experiencing PPD. There is evidence to support a link between depression in

postpartum women and depression in their male partners (Goodman, 2004a; Paulson, Dauber, & Leiferman, 2006; Zelkowitz & Milet, 2001). There is further evidence to suggest that fathers who are depressed during the months following the birth of their child had fewer positive interactions with their infants when compared to fathers who are not depressed (Goodman, 2004a; Paulson, Dauber, & Leiferman, 2006). Overall, the studies supported the findings that postpartum depression developed later in male parents and was not a transient phenomenon (Goodman, 2004a; Zelkowitz & Milet, 2001). Zelkowitz and Milet (2001) found that 60% of the fathers in their study who were diagnosed with psychiatric disorders at 2 months postpartum were still symptomatic at 6 months.

There is mounting evidence that the symptoms experienced by women with postpartum depression are troubling not only to the women but also to their families. Early diagnosis and treatment are critical steps in the promotion of health and the prevention of long term negative consequences for women, their children, and their partners (Beck, 2001; Beck & Gable, 2000; Chabrol et. al., 2002; Field, 1998; Murray & Cooper, 1997; O'Hara, 1995; O'Hara & Swain, 1996; Paulson, Dauber, & Leiferman, 2006; Zelkowitz & Milet, 2001). It is important to design and test interventions that have the potential to be health promoting for families through the primary and secondary prevention of postpartum depression. Maternal-infant behavior patterns are established early so the interventions should be directed at the prevention or early detection and treatment of postpartum depression to avoid a negative cycle of maternal-infant interaction and its sequale.

### Systematic Literature Review

In light of the convincing need for early recognition and treatment of PPD a systematic review of current literature was conducted for the purpose of identifying interventions that fit within the scope of nursing practice and had the potential to be health promoting for families through primary and secondary prevention of postpartum depression. Literature from 1999 to December 2006 was reviewed using the key words “postpartum depression” and “postnatal depression.” The literature was reviewed to answer the questions: (1) is there sufficient evidence-based practice for nursing interventions that have the potential to prevent or decrease the severity and duration of postpartum depression in childbearing women and (2) are there evidence-based interventions from other disciplines that can be appropriately utilized in the practice of nursing to prevent or decrease the severity and duration of postpartum depression in childbearing women?

Sources for the literature search included MEDLINE, Cumulative Index of Nursing and Allied Health Literature (CINAHL), PsycINFO, and SocioFile. The following inclusion criteria were used: (1) an experimental research design with random group assignment or a systematic review of current literature, (2) antepartum or postpartum intervention as an independent variable, and (3) depression or depression symptoms during the first year after delivery as a dependent variable. Excluded from the study were: (1) non-English language publications and (2) interventions that were not within the scope of nursing practice such as the utilization of antidepressants or psychotherapy.

Fifteen published studies were identified that met the criteria for inclusion. Four of these were systematic literature reviews and eleven were experimental designs with the aim of preventing or reducing the prevalence, severity, or duration of postpartum depression in women. Of the eleven experimental design studies, three tested antenatal interventions (Brugha et al., 2000; Hayes, Muller, & Bradley, 2001; and Webster et al., 2003) and eight tested postpartum interventions (Armstrong & Evans, 2003; Armstrong, Frasier, Dadds, & Morris, 2000; Chabrol et al., 2002; Chen, Tseng, Chou, & Wang, 2000; Cooper, Murray, Wilson, & Romaniuk, 2003; Dennis, 2003; & Heh & Fu, 2003; Wiggins et al., 2005).

The content of the interventions in the 11 experimental design studies varied. Three of these studies provided information about postpartum depression. One of the informational studies distributed booklets to women at 28-36 weeks gestation and provided the assistance of a midwife to guide them through the materials at a single antenatal clinic or in-home session (Hayes, Muller, & Bradley, 2001). Another informational intervention mailed booklets to at risk mothers at six weeks postpartum (Heh & Fu, 2003) and the third informational intervention provided women, at their first prenatal visit, with a printed booklet containing information about PPD and a list of phone contacts for PPD resources to (Webster et al., 2003). Four of the studies utilized a cognitive behavioral approach over a series of four to eighteen weeks prior to delivery (Brugha et al., 2000) or in the weeks following delivery (Chabrol et al., 2002; Cooper, Murray, Wilson, & Romaniuk, 2003). The remaining four interventions included: exercise and social support sessions for women experiencing postpartum depression (Armstrong & Edwards, 2003); peer telephone support for moms at risk for developing

PPD (Dennis, 2003); in-home visits to postpartum mothers by a child-health nurse with referrals to social workers as needed (Armstrong, Fraser, Morris & Dadds, 2000) or either home visits by support health visitors or support from community groups (Wiggins et al., 2005).

Antenatal intervention studies failed to detect significantly lower depression scores in the intervention groups as compared to the control groups (Brugha et al., 2000; Hayes, Muller, & Bradley, 2001; Webster et al., 2003). Seven postpartum studies found lower post-intervention measures of PPD in the intervention groups as compared to the control groups and the differences were statistically significant in all of the studies (Armstrong & Evans, 2003; Armstrong, Frasier, Dadds, & Morris, 2000; Chabrol et al., 2002; Chen, Tseng, Chou, & Wang, 2000; Cooper, Murray, Wilson, & Romaniuk, 2003; Dennis, 2003; & Heh & Fu, 2003). Two studies found that both the intervention and control groups experienced statistically significant improvement over time (Armstrong & Evans, 2003; Heh & Fu, 2003). One study found no statistical difference among the intervention and control groups (Wiggins et al., 2005).

The four literature reviews included in this systematic review examined the effects of antenatal and postpartum interventions on PPD. One included a search of the literature for studies that examined the efficacy of antenatal group interventions aimed at reducing PPD in women considered to be at risk (Austin, 2003). The second examined studies on antenatal screening, and primary and secondary prevention studies published the in the year 2000 (Lumley & Austin 2001). The third was a review of studies examining the effect of post delivery debriefing on the prevention of postpartum distress (Gamble, Creedy, Webster, & Moyle, 2002). The fourth was a review to assess the

effects of psychosocial interventions on the risk of postpartum depression (Dennis, 2005). No solid evidence was found in any of these to support the effectiveness of the interventions on the prevalence or severity of postpartum depression in women. Dennis (2005) did find a positive trend related to the provision of ongoing in-home professional support for postpartum women.

### *Sample*

The sample size in the studies ranged from 20 (Armstrong & Edwards, 2003) to 731 (Wiggins, et al., 2005). Power calculations to establish sample size were reported in six of the studies (Armstrong & Edwards, 2003; Armstrong, Fraser, Morris & Dadds, 2000; Brugha et al., 2000; Cooper, Murray, Wilson, & Romaniuk, 2003; & Hayes, Muller, & Bradley, 2001; Wiggins et al., 2005). Of those without power calculations to establish sample size, one was a pilot study (Dennis, 2003), one had a sample size of 258, (Chabrol, et al., 2002), another had a sample of 371 (Webster, et al., 2003) and the remaining two had sample sizes of 64 (Chen, Tseng, Chou, & Want, 2000) and 70 (Heh & Fu, 2003). Attrition rates varied among the studies with the highest being reported by Brugha et al., (2000) at 55%. All of the studies used convenience sampling with random assignment to groups and none intentionally included women from rural areas. All of the samples, with the exception of Webster et al. (2003) and Wiggins et al. (2005), included only women considered to be at risk of developing PPD. The smaller sample size in two of the studies without power analysis calculations and the attrition rate of 55% in another study (Brugha, et al., 2000) are issues of concern related to the validity of these studies.



### *Measurement*

The literature review revealed diversity in the tools used to identify and measure PPD. A total of eight different measures of PPD were used in the studies reviewed. Only one of these measures, the Edinburgh Postnatal Depression Scale (EPDS), was designed and validated specifically for PPD. All but two of the studies included the EPDS as one of the measures of PPD used in their studies. Hayes, Muller, and Bradley (2001) used the Profile of Mood States (POMS) and Chen, Tseng, Chou, and Want, (2000) used Beck Depression Inventory (BDI). The remaining eight studies used either the EPDS alone (Armstrong, Frasier, Dadds, & Morris, 2000; Dennis, 2003; Webster, et al., 2003) or in combination with as at least one other measure of depression. These additional measures of PPD included the BDI (Chabrol et al., 2002; Heh & Fu, 2003), the General Health Questionnaire (GHQ) (Armstrong & Edwards, 2003), and structured diagnostic interviews using the diagnostic criteria of the International Classification of Diseases (ICD-10) (Brugha, et al., 2002), or the Diagnostic and Statistical Manual of Mental Disorders (DSM)-III (Cooper, Murray, Wilson, & Romaniuk, 2003) or DSM-IV (Chabrol, et al., 2002).

### *Discussion*

All but two of the studies (Webster, et al., 2003; Wiggins, et al., 2005) included only women determined to be at risk for developing PPD. There was not, however, a uniform method of identifying those at risk. This is an issue of concern when attempting to compare interventions and outcomes. One study included study participants who were receiving counseling for postpartum depression symptomatology prior to and during the study and slightly more than half of the women in that study were also receiving

pharmacotherapy for their symptoms (Armstrong & Edwards, 2003). No mention was made of attempts to control for this statistically or to determine if there were differences between the intervention and control groups related to this issue or whether the decreases observed in the measures of PPD were related to the intervention, to the ongoing drug therapy and psychotherapy, or to a combination of both. Temporal issues are also a concern in these studies. Post intervention measures of depression were made at different times and often only once. Postpartum depression is believed by some to be non-linear and to exist along a continuum (Ugarriza, 2002). With single measures it is difficult to say much about the effectiveness of the intervention except at that single moment in time when it was measured. These concerns made it difficult to compare and combine findings in a meaningful way or to provide the knowledge needed to inform practice and research. They also raised the question of whether researchers are listening to the women who are experiencing postpartum depression. One issue that is clear is that there is still much about postpartum depression that is not known including successful prevention and treatment modalities to help meet the health and wellness needs of women and their families.

What is currently known is that PPD is not well understood and as a result it is under-recognized and under-reported. There are a number of possibilities for this including women minimizing or not reporting symptoms of PPD to healthcare providers. Women who experience feelings of sadness or guilt at a time they believe should be one of happiness and joy (Ugarriza, 2002) are often not open or comfortable sharing these feelings with their health care providers. Clinicians, on the other hand, may regard the symptoms that are reported to them by women as insignificant or just the “blues” because

of their own discomfort with negative feelings or because they don't fully understand or appreciate PPD (Beck, 2001). Finally, it is known that early detection and treatment are important in the promotion of the health and well being of both mothers and babies (Chabrol et. al., 2002; Field, 1998; Miller, 2002; Murray & Cooper, 1997; O'Hara, 1995; O'Hare & Swain, 1996; Ugazzia, 2002).

There is no shortage of studies that examine the prevalence of PPD but, in spite of the presence of compelling reasons to make prevention and treatment a priority, there are few studies that systematically design and test methods of prevention and treatment. There is not a lack of interest in the phenomenon of PPD as evidenced by continual publication of new articles relating to PPD in health related journals. What is still lacking is an adequate understanding of the experience of PPD as it is lived by women, a conceptual definition of PPD that is shared within and across health related disciplines, and a commitment to finding interventions that have an impact on the development and severity of PPD.

### Culture

Culture has been defined in a variety of ways in the nursing and other health related literature. It is most commonly defined in the more focused context of race or ethnicity but in its broadest sense culture refers to the values, beliefs, practices, habits, likes, dislikes, norms, language, and customs that are learned or socially inherited and shared by individuals in families and communities (Spector, 2004). Culture consciously and unconsciously influences and is influenced by what people believe and experience as well as how they express themselves and relate to others in their environment (Giger & Davidhizar, 1995; Spector, 2004; Wile & Arechiga, 1999).

The cultural milieu has a significant influence on an individual's identity formation as well as the characteristics of the social stresses and supports in his environment. As a result, culture has a significant role in mood disorders and the ways in which an individual within a given culture experiences and expresses symptoms and engages in health-seeking behaviors related those symptoms (Wile & Arechiga, 1999). Because of the influence of culture on the experience and expression of symptoms of mood disorders the behaviors observed may not look or be expressed similarly in all cultures (Wile & Arechiga, 1998). This could have major implications for researchers and clinicians alike in the diagnosis and treatment of PPD.

Although the interaction between culture and mood disorders is recognized it is not fully understood. Until recently it was believed by many that PPD was predominately a phenomenon of Western cultures and only rarely found among women in non-Western cultures. The differences in prevalence rates of PPD found in Western as compared to non-Western populations were theorized to be related to the differences in culture and cultural practices surrounding childbirth (Hung & Chung, 2001; Stern & Kruckman, 1983). The practice of time honored traditions such as "chilla" in Pakistan and Tso-Yueh-Tzu in Taiwan provide new mothers with a period of 30 to 40 days during which they are surrounded by the women of their extended families who care for them and their responsibilities. Such traditions are believed to contribute to lower rates of postpartum depression in these cultures (Hung & Chung, 2001; Posmontier & Horowitz, 2004; Stern & Kruckman, 1983). As technological advances are embraced by an ever increasing number of cultures and the more traditional practices are abandoned, the rates of PPD found across cultures can be expected to become similar world wide increasing the need

to better understand the experience and how to prevent or resolve it (Huang & Mathers, 2001; Postmontier & Horowitz, 2004; Rahman, Iqbal, & Harrington, 2003; Wang, Jiang, Jan, & Chen, 2003).

Recent cultural and transcultural studies of women from different racial and ethnic groups have added to the knowledge of PPD and the role of culture in the ways that women experience this phenomenon (Horowitz, Chang, Das, & Hayes, 2001; Oats et al., 2004; Posmontier & Horowitz, 2004). A qualitative study by Ugarriza (2002) that included urban women with diverse ethnic backgrounds and marital status found women's experiences of PPD to have both similarities and differences when compared to Beck's qualitative (1992, 1993) studies that included almost exclusively Caucasian, middle class, married women. A recent qualitative study of women's perceptions of postpartum depression by Horowitz, Chang, Das, and Hayes (2001) included women from nine different countries and representing both eastern and western cultures. One of the findings of this study was that descriptions of symptoms of PPD were consistent across sites but the meanings that emerged were contextual and differed by country (Horowitz, Chang, Das, & Hayes, 2001). This study also offered the opportunity for insights into how the traditional practices that were protective for women in one culture may well be stress producing for women in other cultures and how similar symptoms were elicited by different circumstances. For example, in cultures with close family networks and traditions of caring for women during the postpartum period, anxiety was attributed to too much advice and interference from relatives but in cultures without close family networks and traditions anxiety was attributed to inadequate social support. One important finding that emerged in this study and was common to all of the women in the

study was their shared wish to have their voices heard (Horowitz, Chang, Das, & Hays, 2004).

### Rural Life

Rural life may summon idyllic images but the stark reality in many rural communities across the country is life in a place that is harsh, isolated, and lacking in the resources needed for healthy lifestyles. Women living in rural communities experience significant barriers to healthcare in general and mental and reproductive health care in particular making the detection, diagnosis, and treatment of depression one of the greatest health care challenges in rural communities (Badger, Robinson, & Farley 1999; Bennett, 2002). Mental health facilities and specialized health care providers are particularly lacking in rural areas increasing the risk for undetected and untreated depression among postpartum women (Badger, Robinson, & Farley, 1999). The result is even greater risks for a population that is already at risk for negative health outcomes (Amankwaa, 2003; Hudson, Elek, & Campbell-Grossman, 2000; Letvak, 2002).

A search of the literature from January 1999 through December 2006 found no studies of PPD or PPDS in women in rural areas of the United States. One quasi-experimental study examined the effects of a 10 week group therapy program in a rural area of Australia with a population of about 31,000 (Lane, Roufeil, Williams, & Tweedie, 2001). The women in that study were compared to urban Australian women in a similar 10 week group therapy program for women with PPD. The study found that the rural population was much more reticent to participate in the study than their urban counterparts. Among the women themselves there was a strong reluctance to accept the fact that they needed help and, unlike the 23% of urban women who joined the study for

preventive reasons, none of the women in the rural group identified prevention as a reason for joining the study. The researchers also found more stringent restrictions on self-disclosure on both a personal and community level in the rural areas as compared to the more urban areas. In the rural population there was an overall sense of belief that the women were strong and should not need help, were accustomed to dealing with hardships on their own, did not expect their husbands to help with childcare, and were reluctant to try new ways of thinking related to their roles as wife and mother. In the first four months of the study only two referrals were received and a prominent member of the community expressed his belief that PPD did not exist in his community (Lane, Roufeil, Williams, & Tweedie, 2001).

### Poverty

Longitudinal data on poverty in the United States show that the majority of those who live in poverty do so for only a short period of time (Iceland, 2003). This is not true in many rural areas and persistent poverty has been found to be overwhelming a rural problem (Miller & Weber, 2003). Many areas of rural America are economically depressed and are plagued with a scarcity of job opportunities coupled with the challenges of low educational attainment, distance, and the lack of transportation (Iceland, 2003). The degree of poverty has been found to increase as the centers of population in counties become more sparsely populated and are located further from urban centers. As the distance from areas of greater population density increases there are generally fewer economic opportunities, lower wages, and a higher rate of unemployment (USDA, 2005; Miller & Weber, 2003). For the past 10 years the unemployment rates have remained consistently higher in rural areas than in urban areas and the loss of jobs in

rural communities has affected the entire infrastructure of these communities (Iceland, 2003; Leight, 2003). The lack of transportation, limited educational opportunities, and few social supports that accompany an ailing infrastructure only compound the problems of poverty in rural areas (Iceland, 2003).

Approximately 25% of the children in America live in poverty and the numbers are growing, especially in the rural areas (Pearson, 2003). In the counties included in this study the percentage of children living in poverty in 2000 ranged from 25.8% to 36.1% (Missouri Kids Count Data Book, 2006). Those born into poverty often remain poor not because of inadequate intelligence or ability but because it is a generational issue that interferes with their ability to see a course of action that would present them with a way out of poverty and into the world of the middle class. Those raised in a culture of poverty learn the patterns, strategies, and interactions of their culture (Pearson, 2003). These learned behaviors are not those by which the middle class operate or in which the poor must interact. Success in a world in which the rules are different from your own and are not made clear makes it difficult if not impossible to achieve economic stability (Pearson, 2003).

Poverty has been found to be a significant risk factor for negative health consequences not only for childbearing women but for all people across the life span (Blumenthal, 2002; Iceland, 2003). A longitudinal study that examined the relationship between PPD and the stressful life conditions of low socioeconomic status found a link between the social settings and interpersonal relationships of new mothers and their mental health status (Seguin, Potvin, St-Denis, & Loisele, 1999). Another study of depression in low-income young minority women found that, even when there was



appropriate care available, few impoverished women were likely to receive the appropriate treatment for depression because of unmet child care and transportation needs (Miranda, et al., 2003).

### Phenomenology

There are a variety of approaches to phenomenology. The focus of each of them is to explicate a phenomenon as it is experienced by humans within the context of their world (Boyd, 2001; Merleau-Ponty, 1956). Phenomenology began as a philosophical movement in twentieth century Germany with the works of Edmund Husserl who is considered to be the father of phenomenology (Polifroni & Welch, 1999). It developed largely as an alternative to the strong presence of the positivist paradigm in the natural sciences (Sadala & Adorno, 2002). Husserl believed that the human experience could not be adequately studied using the rigorous methods of the natural sciences. He believed that human experience should be described as it exists in the world or as it is described by those living the experience rather than through a set of predetermined hypotheses (Sadala & Adorno, 2002). The focus of phenomenology was on the “essences” of everyday realities of life as they manifest themselves rather than as they are counted and interpreted by the researcher (Dowling, 2004).

Husserl’s approach to phenomenology was an epistemological one and, although it was a reaction to the positivist methodologies of his time, traces of the positivism remained in his rigorous and structured approach to phenomenology. His attempt to maintain objectivity through the technique of “bracketing” or setting aside any prior thoughts or beliefs about the phenomenon being studied was a reflection of the Cartesian mind-body dualism (Sadala & Adorno, 2002). He struggled to discover the phenomenon

as it existed in its purest and most objective state and stripped of any relationship to the human experiencing the phenomenon (Dowling, 2004; Husserl, 1964).

Martin Heidegger, a student of Husserl, took a more philosophical and less rigorously objective approach to phenomenology. In contrast to Husserl, Heidegger's approach was more ontological and he placed the emphasis on understanding the very nature of existing or being in the world (Dowling, 2004; Fleming & Robb, 2003; Taylor, 1995). This approach to phenomenology is known as hermeneutic which refers to the theory of interpretation that focuses on understanding. The goal of hermeneutic phenomenology is to uncover the meaning of everyday experiences or the meaning of living in and experiencing the human world (van Manen, 1990). It is both descriptive and interpretive with the realization that the everyday experiences of humans have meaning and the very act of describing the experience is an interpretive process (Munhall, 2004; van Manen, 1990). Heidegger believed that background understandings are always with us and that they cannot be set aside or bracketed out. These pre-understandings play a vital role in the way in which reality is interpreted (Koch, 1996). This was counter to the Cartesian mind-body dualism that was present in Husserl's methodology. For Heidegger, preexisting beliefs and understandings of the world could not be set aside but should be clearly identified and named (Munhall, 2004). The study of a phenomenon or experience of being in the world should be approached with an open mind that would allow one to see a phenomenon that has always been there but to see it in a new light or in a new way (Heidegger, 1996). The phenomenologist must locate himself in such a way that he can be open and even amazed by what he may discover (Boyd, 2001).

Hans-Georg Gadamer, a student of Heidegger, brought to philosophy his beliefs that consciousness is not universal. He saw humans as situated within history and the traditions of their culture which influence and are influenced by them and to which their consciousness is bound (Gadamer, 1960/1989). An important piece of Gadamer's philosophy is the role of fore-meanings or prejudices in understanding human experiences. These prejudices are not to be understood in a negative way but rather as the original meaning of the term prejudice which is "a judgment that is rendered before all of the elements that determine a situation have been fully examined" (Gadamer, 1960/1989 p. 306). It is the familiarity with the fore-meanings or pre-understandings that one holds that provides the ability to move forward into the unknown and see what was previously unseen. It allows one to understand the phenomenon as it is experienced by those living it and, in so doing, to expand one's own experience and sense of the world (Gadamer, 1976).

Gadamer placed great emphasis on the role of dialogue and language in understanding. He said that it is through dialogue with self and others that understanding takes place (Gadamer, 1960/1989, 1976). His approach to phenomenology places a greater emphasis on language and the understandings that come through language than Heidegger's approach (Taylor, 1995). The process of dialogue and its language provide the means through which understanding occurs. There is often an awareness (of things) before one has the right language to express it. This struggle to find the language is a form of inner dialogue and the process of communicating that which is already known. Language is the means through which one understands and is able to express to others that which is understood (Gadamer, 1960/1989, 1976).

It is important when doing phenomenological research to remember that neither researcher nor participant has a privileged position in the interpretation (Koch, 1996; Koch & Harrington, 1998). Both bring their pre-understandings with them. They see the world in which they live from their own horizons or individual vantage points and it is through the fusion of these horizons that one comes to understand the experience and the world in a new and different way (Gadamer, 1960/1989). It is not necessary to make the opinions or understandings of others one's own nor can one cling blindly to their own understandings. What is important is that one brings his own understandings or biases into consciousness and then moves on to being open to the other's expression of his understandings. Pre-understandings will change over time as one engages in the dialogue of all phases of the hermeneutic study. One must be able to tolerate the discomfort of relaxing but not eliminating his pre-conceptions. We understand because of our pre-understandings rather than "in spite" of them (Koch, 1996).

## CHAPTER III: METHODOLOGY

### Research Design

It is the question and not the researcher that should determine the research design (Gadamer, 1960/1989; van Manen, 1990). In this study the research question is: “What is the lived experience of rural Missouri Ozark women with postpartum depression symptoms?” The question is a qualitative one and thus requires a qualitative methodology. In hermeneutic phenomenology that is guided by Gadamer’s philosophy, the aim is to gain a new or different understanding of the meaning of everyday experiences (Gadamer, 1960/1989; van Manen, 1990). This makes Gadamer’s approach to phenomenology an appropriate choice for a study that seeks to understand the experience of rural Missouri Ozark women who are living with postpartum depression symptoms.

The Ozark area is one of the oldest land areas in the world. It rose from the sea millions of years ago and evolved into a “hilly island” laced with thousands of caves, rivers, and springs (Stevens, 1991). As the settlers in the “new land” began to migrate westward the Ozark area attracted a group of uncommonly strong and independent people happy to live apart from the growing complexities of civilization. Many settled in valleys known as hollows. The inhabitants of these hollows became close-knit communities and were, for the most part, isolated from the rest of the world (Stevens, 1991). Over the years the area has developed a culture of its own. The men and women of the Ozarks maintain a powerful sense of dignity and pride in their culture and in their abilities to deal with the hardships of this rural and sometimes isolated area. They love and are at home amid the beauty and comfort of the hills with their rivers, springs, and abundant wildlife.

They experience life and have an understanding of the “way things are” that has come to be their own. The lack of research targeting women in this rural culture and the knowledge that there are contextual differences in women’s experiences of PPD make phenomenology an appropriate research design for this study.

It is critical to understand the uniqueness of the participants’ culture, including the geography and the culture's influence on social organization. Gadamer’s (1960/1989) philosophy which includes a view of humans as situated within the history and traditions of their culture guided this study and provided the framework in which the experience of postpartum depression symptoms could be seen and understood in a new or different way.

### Setting

The setting for this study is a very rural area of the Missouri Ozarks that is rich in natural beauty and traditions. The target counties included in this study are among some of the most rural counties in the United States. There are few racial and ethnic minorities represented in this population and poverty is chronic in this area. The average population density of the area is 10.25 residents per square mile and there are no cities or towns with a population of 2, 000 or more in any of these counties (Missouri Census Data Center, 2000). Almost one third of the adult population (31%) in the area reports being disabled, high school drop out rates are high, and the topography of the area is unsatisfactory for commercial farming (USDA, 2006). The average median household income in the targeted counties was \$25,753 in 2004. This is about 63% of the \$40,885 that was the median household income for the state of Missouri in 2004 or 58% of the national median household income of \$44,444 (United States Census Bureau, 2007). The land is

predominately rural and much of it is occupied by the Mark Twain National Forrest and 134 miles of National Scenic Riverways (National Park Service, n.d.). The nearest obstetrician or mental health care provider is an average driving distance of 50 miles on rural, county or state roads and highways. There is no public transportation and many residents depend on old and often unreliable vehicles or rides from family or friends. Those who do have working vehicles often do not have money for gasoline or live on roads that can be hazardous, especially during spring floods and winter storms. Many of the residents have no telephones and, for those who do, most phone calls are long distance or toll calls. Computers are rare and television reception is almost nonexistent without satellite service further isolating them from the world outside their communities and often outside their homes. For some women the only communication with the world outside their homes is visiting with friends and relatives.

Interviews took place in the naturalistic setting of the women's homes or other mutually agreed upon location that afforded them a sense of comfort and security. One interview took place on the participant's porch, one took place in a restaurant about seven miles from the participant's home, and all others took place in their homes. Often this home was one the woman shared with her parents. All interviews were informal and conducted in the format of a visit which supported dialogue and was acceptable to the majority of women in the target population. It also eliminated the need for the women to find transportation and childcare.

### Sample

Women living in the counties targeted for this study were the focus of this study because of the population density and scarcity of resources in these counties, their

distance from urban areas, and the familiarity of the researcher with the area and its residents. Women were eligible for inclusion in the study if they: were at least 18 years of age; were receiving Medicaid or Missouri MC+ benefits or had received them at the time of delivery; delivered a healthy term infant of at least 37 weeks gestation; were one to twelve months postpartum; lived in one of the target counties; and were experiencing at least two symptoms of postpartum depression as they are described in the DSM-IV-TR (American Psychiatric Association, 2000) or the Postpartum Depression Screening Scale (Beck & Gable, 2000). Women with a history of a psychotic or long term major depression outside the perinatal period were excluded from the study. The decision to include only those women receiving Medicaid or Missouri MC+ was influenced by the impact of poverty on the experiences of women living in the very rural areas of this country.

The findings in qualitative studies are not intended to be generalizable but may be transferable to similar populations. Random sampling is neither necessary nor appropriate in phenomenology. It is necessary, however, to disclose the methods used for sample selection to assist the reader's decision regarding transferability (Higginbottom, 2004; Sandelowski, 1995). There are no formulas or power analysis calculations for determining sample size that are useful in qualitative research. Because of the in-depth nature of interviewing that is involved in phenomenology the sample size is typically small with possibly as few as six participants (Higginbottom, 2004; Sandelowski, 1995). The aim of phenomenology is to provide the reader with insight into the lived experience of a phenomenon so the sample size should be small enough to allow for the in-depth nature of interviewing and large enough to provide access to sufficient data to provide a



richness of understanding of the phenomenon (Higginbottom, 2004). The anticipated sample size for this study was 6-12 with and a total of 12-36 interviews. The actual sample size was 10 postpartum women and a total of 27 interviews.

The method of sampling planned for this study was a combination of purposive and snowball sampling. This combination of sampling techniques is appropriate to satisfy the needs of this study and to increase the likelihood that all women with PPDS are provided an opportunity to be included. None of the women in the study identified other women who met the eligibility criteria for the study eliminating the opportunity for snowball sampling.

#### Procedures

Participants were recruited from a population of postpartum women participating in programs at county health centers or through maternal-child outreach services in the rural counties included in this study. Prior to the recruitment stage of the study, appointments were made at the county health centers and a maternal-child outreach agency serving the targeted area to explain the study and elicit their help in identifying women who might meet the eligibility criteria and be willing to participate in the study. Informal visits to maintain contact and visibility at these agencies continued at three to six month intervals throughout the study. This served the two-fold purpose of gaining access to possible study participants and eliciting the cooperation of these agencies rather than suspicion or distrust. The agencies approached were open to learning about the study and agreed to invite women they believed would meet the eligibility criteria to learn more about the study. There was at least one contact person at each agency to give women information about the study and to obtain the names, telephone numbers and addresses

for those who expressed interest in participating. The researcher then contacted the women by telephone or in person, if there was no phone, to make an appointment for a face to face meeting. The purpose of this first meeting was to explain the study, complete the eligibility criteria checklist, and obtain informed consent from women who met the eligibility criteria and agreed to participate in the study. For the women who were enrolled in the study, a date and time for the first interview was mutually agreed upon by the researcher and the participant.

### Trustworthiness

Both qualitative and quantitative methodologies have criteria by which the quality of the research can be evaluated and, although the criteria and terminologies differ, the quality of the study is essential in both paradigms. In quantitative research the central measure of quality is validity, a measure of the truth or veracity of the study's claims (Burns & Grove, 2001). In qualitative methodologies the corresponding concept or measure of quality is often referred to as rigor or trustworthiness. In quantitative studies the validity and reliability of the instruments used to collect and measure the data are critical and must be provided for the reader to use in evaluating the validity and reliability of the study. In qualitative studies, because the focus is on understanding rather than measurements (Janesick, 2000; Polit & Beck, 2004), the researcher's ability to hear, understand, interpret and report what the participants are revealing about their experiences is critical to the quality of the study and must also be made visible to the reader.

Qualitative research encompasses a variety of research methodologies and, because of that fact, there is no single set of criteria that can be used to evaluate the

quality or trustworthiness of all qualitative studies (Emden & Sandelowski, 1998; Mays & Pope, 2000; Morse, Barrett, Mayan, Olson, & Spiers, 2002; Sandelowski, 1993). The researcher must select criteria that are appropriate and philosophically consistent with the methodology being used and present the reader with enough detail to make a judgment about the quality or trustworthiness of the study (Creswell, 1998; Koch, 1996; Rolfe, 2006; Sandelowski, 1993). It is the responsibility of the researcher to ensure trustworthiness throughout the research process, the reader to make a post hoc judgment regarding the quality and relevance of the project, and the report to serve as an envoy between the two (Creswell, 1998; Morse et al., 2002; Sandelowski & Barosso, 2002; Tobin & Begley, 2004).

Lincoln and Guba (1985; 2000), Sandelowski (1986), Beck (1995) and others have proposed criteria for establishing the trustworthiness of qualitative studies. A comparison of the three mentioned above revealed more similarities than dissimilarities among them (Koch, 1994). Of these, Lincoln and Guba's (1985; 2000) criteria are the most commonly used in nursing and health related qualitative research. Their criteria of credibility, transferability, dependability and confirmability have been evaluated and reaffirmed in later publications by Guba and Lincoln (1994) and Lincoln & Guba (2000). In addition to these methodological criteria, the trustworthiness of the interpretation has been the focus of more recent attention (Lincoln & Guba, 2000). There is no single method by which the reader can judge whether the interpretation is trustworthy enough to act upon but there are criteria the researcher can use to assist in this evaluation process. Lincoln and Guba (2000) have suggested the criteria of authenticity, resistance, transgression, ethical relationship, voice, and reflexivity as some possibilities for use in

evaluating interpretive validity. Sandelowski (1993) and Sandelowski and Barroso (2002) have emphasized the crucial role of the written report in reader's process of evaluating the quality or believability of a study. The report itself should be written in such a manner as to be compelling and, have the ability to move the reader to see the value of the study (Sandelowski and Barroso, 2002). In the present study, the criteria of credibility, transferability, dependability and confirmability will be used to guide the methodological trustworthiness of the study. The presence of voice, reflexivity, relevance, and an ethical relationship with the study participants will be reflected in the written report to provide the reader with data needed to make a post-hoc evaluation of the quality or trustworthiness of the project.

### *Credibility*

Credibility refers to the clear and faithful reporting of the phenomenon as it is experienced and described by the study participants. In this study the interviews were recorded (voice recordings) and field notes were written as soon as possible after each interview to record the participants' non-verbal responses such as body language and facial expressions and surroundings. Journal notes were written to capture the researcher's thoughts and feelings regarding the process. Voice recordings were transcribed by the interviewer and the recordings and transcripts were compared for accuracy. At the second interview the transcripts were returned to the participant to review. The first two interviews in the second round of interviews were not voice recorded but notes were written by hand. All remaining second round interviews were voice recorded. In Gadamerian hermeneutic phenomenology the participants are a critical part of the process. According to Gadamer (1960/1989), it is through the dialogue

that occurs between the researcher and the participant that understandings are shared and horizons are fused. It is not possible to completely understand another but through shared understandings we can begin to see “in a different way” (Gadamer, 1960/1989 p.297). At the third and final interview the study participants were presented with the interpretation of the phenomenon and simply asked “what do you think?” The purpose of this third round of interviews was not primarily for verification or member checking but, rather, to invite dialogue that allows the researcher to gain insights and continue to see the phenomenon in a new or different way.

Credibility of both the process and outcome were also strengthened by the presence of a nurse researcher with extensive research experience with low income childbearing women in a neighboring and similar rural area of Missouri and a nurse researcher with experience in hermeneutic phenomenology. The former read the report for resonance and the latter for integrity of both the process and outcome. Moreover, their involvement afforded additional opportunities for understanding PPDS in rural women as a result of the dialogue and sharing of understandings that resulted from their involvement.

Self-awareness also plays a crucial role in credibility (Koch, 1994). The researcher must explore what Gadamer refers to as fore-meanings, pre-understandings or prejudices (Gadamer, 1960/1989 p.306). These original meanings or understandings are the starting points for understanding the phenomenon in a different way. The pre-understandings that are present in the consciousness before the phenomenon has been “fully examined” (Gadamer, 1960/1989 p. 306) are the understandings with which the researcher dialogues as she strives to gain a new and different understanding of the

phenomenon being studied. It is not possible to set aside or bracket out these pre-understandings and it is actually through them that we can come to understand the phenomenon of interest in a new or different way (Gadamer 1960/1989). In this study there was an on-going reassessment of pre-understandings during the interviews, as recorded interviews were being transcribed, and at a variety of other points throughout the study. This was accomplished through journaling, writing field notes, and engaging in the internal dialogue and questioning pre-understandings in order to make sense of what the women in this study revealed about their experiences of PPDS.

Finally, the credibility of the researcher must be examined and made available to the reader. For the purposes of this study it is important for the reader to know that I have spent the majority of my career as a nurse working with ethnically and culturally diverse populations. Twenty-eight of those years were spent working in some capacity with women in a perinatal setting. In addition to this, I have spent the past eight years living and doing nursing outreach work among pregnant and parenting women and their families in the rural area of the Missouri Ozarks targeted for inclusion in this study. During my years living and working in the rural area that was the focus of this study, I became familiar with the culture and traditions of the people in this area and earned the trust of the community to the extent that this is possible for an “outsider.”

### *Transferability*

Transferability refers to how well the findings of the study can be generalized to another population or how well it may “fit” another population. There is no single interpretation of an experience or phenomenon and we are reminded by Gadamer (1976) that humans are always situated within the traditions of history and culture. The

understanding gained can only be transferred from one context to another if the two are similar enough. It is essential that the context of the study be adequately described to enable the reader to make a judgment regarding the meaningfulness and applicability of the findings to another population of interest (Sandelowski, 1986). The term applicability is more appropriate in the Gadamerian tradition than “transferability” and it is important to remember that neither can be established by the researcher. In this study, adequate descriptions of settings, populations, and context were described to supply the reader with the data necessary to make a decision regarding the applicability of findings.

### *Dependability*

Dependability refers to how dependable the findings are or the congruence between the researcher’s interpretation of the phenomenon and what the participants actually described. To establish dependability the researcher must document every decision and step of the research process. This audit trail that is created demonstrates for the reader how the researcher arrived at conclusions or interpretations. It allows the reader to see that both the process and the product are trustworthy (Guba & Lincoln, 1994; Koch, 1994). Dependability demonstrates that the conclusions were arrived at honestly and that another researcher could arrive at similar although not necessarily the same conclusions (Sandelowski, 1986).

In this study transcripts, field notes, journal notes, and quotes from interview texts that support the interpretations as well as a soundly documented decision trail are part of the process and are included and visible in Chapter IV of this report. It is important to note, however, that dependability is not essential, may be unwarranted, and overzealous attempts to confirm it may actually weaken the argument for validity or trustworthiness

(Sandelowski, 1986). Dependability conceptualized as repeatability is incongruous with the concept of multiple realities and the historical and cultural context to which realities are bound.

### *Confirmability*

Confirmability refers to the presence of adequate data to determine that the process and product are real and not invented by the researcher. It provides an opportunity for the reader to see how the interpretations were arrived at. Confirmability can only be achieved in conjunction with or as a product of the previous criteria of credibility, transferability, and dependability (Koch, 1994; Whitehead, 2004). The belief that consciousness is influenced by history and culture and is not universal (Gadamer, 1960/1989) makes confirmability, in the strictest sense of confirming the findings as truth or reality, an inappropriate criterion for hermeneutic phenomenology. In the sense that confirmability allows the reader to see and confirm how the researcher arrived at conclusions, this criterion can be useful to guide the quality of the study. In this study the standards of credibility, transferability, and dependability guided the process and the transparency of that process provides the reader with the data needed to make a decision regarding confirmability of the claims or of the researcher's ability to see what was previously unseen.

### *Voice*

Voice in this study refers to allowing the voices of both researcher and participant to be heard through the reading of the written report. The voices of the participants can be heard through the inclusion of multiple direct quotes in the text. This allows the reader to actually hear what the participants had to say and wanted others to hear about their



experiences. The voice of the researcher can be found in the practice of reflexivity throughout the study.

### *Reflexivity*

Reflexivity is the researcher's questioning and understanding of self and of the forces that have influenced her (Patton, 2002). It includes observing and questioning the interactions that occur between researcher and participant; how the researcher's experiences and perspectives may be affecting the data as it is collected and analyzed; and how the participants are affecting the researcher's perspectives (Patton, 2002). Reflexivity is essential in the establishment of a sound qualitative study. The pre-understandings or prejudices and the ongoing dialogue that are essential in Gadamerian hermeneutic phenomenology can only be realized through the process of reflexivity. Reflexivity was a part of this study from its inception. The thoughts, insights, and decisions that were made throughout have been incorporated into the report beginning with the description of the questions and decisions that influenced the study design. This inclusion of reflexivity in the written report allows the reader to make a post hoc evaluation of the study and the contribution it makes to knowledge about postpartum depression symptoms in rural Ozark women.

### *Relevance*

In judging the quality of a research project it is also important to evaluate its relevance (Munhall, 1994). The emphasis of hermeneutic phenomenology is to uncover the meaning of everyday experiences as they exist in the human world (van Manen, 1990). Phenomenology should be relevant to the researcher, the science, and those who are experiencing the phenomenon of interest and it should bring us closer to an

understanding of humanness (Munhall, 1994). The relevance of this study to the researcher and the women in the study is reflected in the written report and the readers of the report must decide the relevance of the study for their own research or clinical practice. While the relevance will not be the same for all, the results of this study will extend our understanding of postpartum depression symptoms in rural women. A view of PPDS from a fresh perspective challenges health care professionals to consider a broader approach to recognizing the symptoms of postpartum depression in rural women and to see the conflict of priorities that may exist between health care professionals and the women they serve. It is essential to see the postpartum experience within the rural context to have a better understanding of the needs and challenges faced by postpartum women living in rural areas.

#### *Ethical relationships*

The researcher must have a sense of genuine respect for the participants and always strive to avoid engagement in a study that is purely exploitative (Munhall, 1994; van Manen, 1990). Lincoln and Guba (2000) have constructed a list of seven standards to be considered by the qualitative researcher as guidelines for establishing and maintaining ethical relationships within qualitative research. These include: positionality, discourse communities or research sites as arbiters of quality, voice, critical subjectivity, reciprocity which includes a balance of power, profound regard for how science can contribute to human flourishing, and sharing the perquisites of privilege (p.182). These standards, with the exception of discourse communities or research sites as arbiters of quality which is not appropriate in the present project, are woven throughout the study and are identifiable in the practice of reflexivity and its account in

the written report. In addition to these points, the protection of human subjects through the role of the institutional review board and informed consents are essential in meeting our ethical responsibilities to participants. These are discussed in greater detail later in this chapter.

### Data Collection

Women who expressed a willingness to learn about the study were contacted by phone and an appointment was made for a face to face meeting to explain the study. During the first meeting, I explained the purpose of the study, how it would be conducted, the types of questions that would be asked, and the measures that would be used to maintain confidentiality. For those women who remained interested in participating, the eligibility criteria check list was completed and informed consent obtained. Handwritten notes of the women's responses were taken during the process of completing the eligibility criteria check list. At the conclusion of this first meeting a short demographic data sheet was completed and a time and place were agreed on for the first taped interview. At the conclusion of the first meeting each participant was given a folder with a copy of the informed consent, a calendar with the date and time of the first interview noted, and a card with a toll free 800 telephone number that could be used to reach me for the purposes of canceling or rescheduling an interview.

All participants were told during this first meeting that my sole purpose was to interview them as a means of learning about their experiences with postpartum depression symptoms and it was not to provide any kind of therapy or help with their symptoms. They were reminded that, as a health care provider, I was a mandated reporter and any signs of child abuse or neglect as well as statements that would lead me to

believe that they intended to harm their child would have to be reported to family services in their county. Additionally, the women in the study were informed that if they expressed an intention to harm themselves, they would be immediately referred to their physician or other health care professional for evaluation.

Participants were interviewed in the naturalistic setting of their homes or other mutually agreed upon location that afforded them a sense of comfort and security. One participant chose to be interviewed on her side porch and another chose to meet at a restaurant approximately seven miles from her home. All other participants chose to be interviewed in their homes. Voice recordings were made during these interviews. Each interview began with an informal conversation or visit phase during which the researcher and the participant talked about what had been going on, the weather, the baby, holiday preparations, or whatever the participant chose. If the conversation turned to a topic related to postpartum depression symptoms, the researcher turned the voice recorder on with the permission of the participant. At each interview session the participant was reminded that the interview would be taped and she was asked for permission to begin the recording. Because the interviews took place within the context of an informal visit the voice recorders were placed between the interviewer and the participant in an unobtrusive location. After the first few interviews both a tape and a digital recorder were used for each interview. The combination of the two methods provided better quality and made transcription of the interviews easier and more accurate in most cases. Two methods of recording also provided a back up if one or the other method failed. Only one of the participants seemed to be bothered or somewhat intimidated by the presence of the

recorder but when given the option of stopping and using the recorder for “practice” to get more comfortable with it before continuing she declined and the taping continued.

The initial question posed to each woman was: “What has it been like for you since your baby was born?” If the symptoms began during pregnancy, she was asked: “What has it been like for you since your baby was born or, if you started feeling depressed (or however the symptoms were described at the initial meeting between the interviewer and participant) during your pregnancy, since then?” The answers the women gave to questions about their symptoms of postpartum depression on the eligibility criteria check list were used as a semi-structured interview guide to assist both the researcher and participant to focus on the experience of each individual woman. Additional probes were determined by the dialogue. Interviews were taped, digitally recorded, or both. Each initial interview was followed with a second interview to provide the opportunity for the participants to offer additional information and for the researcher to clarify her understanding of the data from the previous interview. A third and final interview provided one more opportunity for dialogue and for the researcher to continue to gain new insights and understandings of the phenomenon as well as to clarify and verify current understandings and the meaning of the experience of living with postpartum depression symptoms. Dialogue is a central concept in Gadamer’s approach to phenomenology and requires returning to the participant. The transcript of the interview and the researcher’s preliminary analysis was used to stimulate dialogue and shared understandings (Gadamer, 1960/1989; van Manen, 1990). The inclusion of the second interview allowed issues to be revisited and new areas to emerge as the level of comfort and trust developed in the relationship between researcher and participant.

In addition to voice recorded interviews, data collection included demographic data sheets, eligibility criteria checklists, field notes, and journal notations. Field notes were completed after each interview and include descriptions of the interview surroundings, participants' nonverbal responses such as body language and facial expressions, and the researcher's thoughts and feelings regarding the interview and environment. These notes were transcribed and attached to the typed transcripts of the interview. The process of writing field notes situates the researcher to challenge her preconceptions and have the preconceptions challenge her findings (Gadamer, 1960/1989).

#### Protection of Human Subjects

Approval for human subjects research was received from the University of Missouri at St. Louis Institutional Review Board prior to recruitment of study participants. Administrative approval was obtained from recruitment sites prior to initiating the study. Before enrollment in the study, written informed consent was obtained from each woman. All efforts were made to maintain the confidentiality and identity of study participants. All voice recordings of interviews were transcribed by the researcher. Voice recorded interviews, written transcripts of the interviews, demographic data sheets, and eligibility criteria checklists were identified by non-sequential identification codes and kept in a locked file cabinet to which only the researcher had a key. Personal identification sheets containing the participant's name, identification code, telephone number or contact number, mailing address, and directions to her home were kept in a separate locked file. Participants' comments were not identified in the final report by name, county of residence, or any other piece of identifying information. Taped

voice recordings will be destroyed within five months of the completion of the study. Digital recordings were erased after they were transcribed and the transcripts were compared to the recordings for accuracy.

Prior to beginning the first interview, the research process was explained to each participant. This included an explanation of the purpose of the study, the role of the interviewer, interview procedures including the use of voice recorders, approximate amount of time that would be required for each interview, number of planned interviews, and the type of data to be collected during the interview, specifically, women's thoughts and feelings about experiencing symptoms of PPD. In addition to an explanation of the interview process women were advised that their anonymity would be protected by removal of names from all transcripts, demographic data sheets and eligibility criteria check lists. Women were advised that they were free to decline to answer any questions that they felt might cause discomfort, and that they had the right to withdraw from the study at any time.

#### *Potential Risk to Subjects*

There were no risks identified except for the possibility of discomfort that could arise as a result of thoughts that surfaced during interviews and the possible loss of privacy if sessions took place in the context of a home visit. As protection against these risks, women were given the option of being interviewed in their homes or another mutually agreed upon place that might offer them a greater sense of comfort and privacy. Voice recorded interviews were not made available to anyone other than the interviewer and members of the researcher's dissertation committee. What the participant discussed with the interviewer remained within the control of the participant at all times.

There was a plan in place for any study participant who disclosed thoughts of death or suicidal ideation, or plans or attempts to harm self, infant, or anyone else to be immediately referred to her physician, the regional family counseling center, or other local licensed counselor for evaluation. A follow-up phone contact would be made within 24 hours to be certain she had been able to access the health care system and, if not, she would receive the assistance needed to gain access to an appropriate health care provider. Any woman whose symptoms were troubling to them or who requested diagnosis and treatment for PPD would be encouraged to call her physician and would also be given contact information for the regional family counseling center, or a licensed counselor to decrease the risk of undiagnosed and untreated postpartum depression. A follow-up call would be made to these women within 72 hours to be certain that they had been able to access the mental health care system and, if not, to provide whatever assistance was needed for them to access a health care provider. Two women in the study disclosed thoughts of harming themselves in the past but added that these were not current thoughts. One gave permission for the researcher to contact her primary care nurse to set up an appointment for her to see her physician or a counselor and this was done. The other woman had been seen by a counselor in the past and had established a sense of trust with her; she made and kept an appointment with this counselor after the first interview. At the time of the second interview this woman was taking an antidepressant as well as a bedtime dose of hydroxyzine for insomnia. No other women were taking antidepressants or receiving counseling at the time of the interviews.



## Strengths and Limitations

### *Strengths*

This qualitative study provides an understanding of the phenomenon of postpartum depression symptoms within a rural context and provides knowledge needed prior to developing future interventions that are grounded in the life-world of the participants rather than that of the researcher. It also adds the perspective of rural women who are experiencing postpartum depression symptoms. This is a perspective that has been absent and one that has the ability to help clarify and expand health care professionals' knowledge and understanding of this phenomenon. Things must be viewed from a variety of perspectives to allow a more comprehensive understanding of the whole, otherwise we see in profile or only from the vantage point of one side (Giorgi, 2005). The greatest strength of this study is the openness and willingness of the women in this study to share their experiences with all of those who will listen their voices.

### *Limitations*

One noteworthy limitation of this study is the possible exclusion of women with the most severe symptoms or the greatest sense of isolation. As a result of this possibility, the understanding of postpartum depression symptoms as they are experienced by women living in rural areas may be somewhat limited. Additionally, the experiences as they are lived by these women cannot be generalized to all women living in rural areas; lived experiences are shaped by the time and context in which they occur.

### Data Management and Analysis

Following data collection, recorded interviews were transcribed verbatim and the names and other identifying information such as the names of their infants or other family members, county of residence, place of employment, or names of physicians were removed from the typed transcripts. The format used for data analysis was in keeping with Gadamer's approach to hermeneutic phenomenology as described by Fleming and Robb (2002) and van Manen (1990). After the tapes were transcribed they were listened to and compared to the transcripts for accuracy. At this time notations were also made regarding changes in the volume and tone of the participant's voice and length of pauses. These notations, combined with memory of nonverbal behaviors and field notes made soon after the interview, were included as part of the analysis. Interview texts were then analyzed as follows:

1. The text of each interview was read in its entirety to gain an overall meaning.
2. Interviews were summarized.
3. Each interview was re-read looking at each sentence or section to reveal the experience of living with postpartum depression symptoms and to begin to identify themes.
4. Each sentence or sentence cluster was examined to see how it related to the meaning of the text as a whole. Notations were made to link the meaning to the text.
5. Relational themes, those that were common across all texts, were identified.
6. Interpretations of meaning were compared to descriptions of the phenomenon from the literature.

7. Validation of analysis by other members of the dissertation committee familiar with the research method or with the phenomenon and the population was obtained. Dialogue and return to the interview text was used to clarify differences in interpretations or gain new understandings.
8. A third round of interviews was conducted for dialogue and reflection on the overall analysis of the interviews. This provided an opportunity for discussion of more feelings or thoughts related to the experience of postpartum depression symptoms as well as to clarify the interpretations as reflections of the participants' experiences and to engage in dialogue that might lead to new understandings.
9. An overall description of the phenomenon of postpartum depression symptoms in rural Ozark women was constructed. Passages that represent shared understandings between the researcher and participants were used to provide the reader with insight into the aspect of the phenomenon and to allow the reader to validate the findings.

## CHAPTER IV: FINDINGS

In this chapter, I will allow the women themselves to tell their stories. The particulars vary from woman to woman but their experiences bear many similarities. Each woman was invited to participate because she was experiencing at least two of the symptoms of postpartum depression as they are described in the DSM-IV-TR (American Psychiatric Association, 2000) and the PPDS (Beck & Gable, 2000); each woman chose to participate because she had a story to tell about her experience that she wanted heard. It is only reasonable to allow their voices to be heard in the telling of their stories. The names used in the telling of these stories are fictitious. Pseudonyms were used to protect the identity of the women who participated in this study.

### The Participants

The participants in this study were ten women who lived in three rural counties in the Missouri Ozarks. At the time of enrollment, the mean age of the women in the study was 22.7 years and the mean age of the infants was 5 months. Four of women were first time mothers, four had one other child, one had two other children, and one had three other children. Four of the women were married and the remaining six were not married at the time of this study. Of the women who were not married, three were living with the father of their children, two were estranged, and the father of one was incarcerated. Four of the women worked outside of the home and were the main source of income for themselves and their children, one worked part time to help with the basic needs, and two of the women were on Temporary Assistance to Needy Families (TANF). One of the women, who had been employed at the time of enrollment, was not able to continue with

her employment because of the overwhelming nature of her job and home responsibilities. Eight of the fathers were employed at least intermittently; four provided the main source of income for the family, two contributed some financial support, and the remaining four did not contribute to the support of their children. Of the two women on TANF, both had worked previously and one discussed returning to work as soon as she could find employment. All of the women were eligible for Missouri MC+ or Missouri Medicaid at the time of delivery. Table 1 presents a summary of the demographic data.

Table 1

Demographic Data Table

	Maternal Age	Infant Age	Living with relatives	Number of children in home	Number of adults in home	Lives with FOB <sup>1</sup>	Employment status	Source of income
Sofie	27	7 months	Yes	4	2	No	Employed	Self
Elaine	19	6 months	No	1	2	Yes	Homemaker	Husband
Rebecca	23	6 months	Yes	2	4	Yes	Part time	Self/FOB <sup>1</sup>
Tammy	23	6 months	No	3	2	Yes	Homemaker	Husband
Lauren	21	2.5 months	Yes	1	3	No	Unemployed	TANF
Wendy	21	7 months	Yes <sup>2</sup>	2	5	Yes	Homemaker	Husband
Gretchen	25	3 months	No	2	2	Yes	Homemaker	TANF
Martha	26	4 months	No	1	1	No	Employed	Self
Elizabeth	19	7.5 months	Yes <sup>2</sup>	9	2	No	Employed	Self
Patricia	23	6 months	Yes	1	3	Yes	Employed	Self

NOTE: Demographic data collected at the time each woman enrolled in the study.

<sup>1</sup> - Father of the baby

<sup>2</sup> - Moved into her own place during study

### Thematic Analysis of the Data

Initially the texts of the interviews, field notes, and journal entries were read, examined as a whole, and summarized. The texts were then re-read to begin to identify themes. During the first round of thematic data analysis, any words, phrases, or notations about changes in voice, emotions, or demeanor that were interesting, unexpected, or

seemed in other ways to be significant were underlined. Those that communicated a similar meaning were grouped together. These groupings resulted in a preliminary list of 18 themes:

- Overwhelmed
- Anxious
- Stressful Living Arrangements
- Irritability
- Emotional Lability
- Exhausted
- Insomnia
- Loss
- No Time For Self
- Financial Concerns
- Being Alone
- Sadness
- Stranded
- Isolated
- Bearing The Responsibility
- Putting Kids First
- Child Care Concerns
- Guilt

The texts were read a third time and it became clear that there was overlap between the themes of Irritability and Emotional Lability, Stranded and Isolated, and

Exhausted and Insomnia. These six were collapsed into the three themes of Irritable, Isolated, and Exhausted. After a fourth reading, Loss and No Time for Self were determined to be overlapping and were combined as the theme of Loss. The women's descriptions of Bearing the Responsibility, Putting Kids First, and Child Care Concerns had significant overlap and were combined into the theme Fiercely Responsible. These changes reduced the number of themes and, as a result, the second list contained 12 themes.

The texts were read a fifth time and the sentences, words, and phrases were highlighted and coded according to the existing list of themes. Journal entries and field notes were also re-read. As a result of these readings, Guilt was not found to be present in the interviews of all of the women and it was removed from the list of themes. After this fourth reading I attempted to step back and again examine each interview as a whole to determine what these women were saying and what they wanted heard about their experiences with postpartum depression symptoms. First and foremost, all of these mothers were overwhelmed and stressed. The themes of Anxious, Irritable, Exhausted, Financial Concerns, and Loss were considered to be a part of the same experience and were combined into the theme of Overwhelmed and Stressed. The women's descriptions of their Stressful Living Arrangements were largely accounts of having their parenting skills and abilities judged by their families, health care providers, and neighbors or feelings that their families were trying to control at least some parts of their lives. This prompted me to retain Stressful Living Arrangements as a separate theme and it was renamed Controlled and Judged. It remained clear that the women who participated in this study also felt: sad, alone, and deserted by those on whom they had depended for



help and support, a sense of isolation from people, places, opportunities, and services, and a fierce sense of responsibility for their children. At this fifth reading the theme of hopes and dreams emerged and was added to the list of themes. For most of the women, these hopes and dreams were small but each of them expressed some hopes for their future. The result of these readings of the texts, journal entries, and field notes was a revised list containing six themes. These themes were:

- Overwhelmed and stressed
- Controlled and Judged
- Deserted
- Isolated
- Fiercely Responsible
- Hopes and Dreams for the Future

The themes Deserted and Isolated were questioned by the nurse phenomenologist as possibly being one theme. After clarifying the definitions of both, a preliminary decision was made to keep them as distinct themes but to exchange the term deserted for abandoned. Isolated is conceptualized as being separated from people, goods, and services as a result of geographic or social barriers. Abandoned is conceptualized as being deserted, forsaken, or left alone. Both Isolation and Abandonment include an element of aloneness but the key difference here is that Abandonment is the process of losing or having lost someone or something that was once there. Isolation is being separated from someone or something but does not necessarily imply that it was something to which one previously had access. The emotional elements of Isolation and Abandonment make them especially significant aspects of the women's experiences with

postpartum depression symptoms. Isolation may engender a variety of difficulties including anger, frustration, and even loneliness but, in addition to these, abandonment evokes a strong sense of disappointment and hurt. In these interviews, I heard that abandonment hurts; it causes pain, disappointment, and often anger. Isolation, on the other hand, is a frustration and a barrier but does not cause the hurt that accompanies abandonment. The women in this study were abandoned by friends, relatives, and the fathers of their children; they were isolated, predominately, from goods, services, and opportunities for financial and educational advancement.

The texts from each of the interviews were read for a sixth time and statements were highlighted and coded by themes. On this sixth reading of the data it became clear that Financial Concerns, permeated most of the themes making it apparent that it should be a separate theme. The strong sense of Loss that was experience by all of these women was re-examined. It was decided that what these women had to say about the presence of Loss in their lives was universal, significant, and warranted keeping it as a theme.

A table was constructed to assure that each theme was, in fact, present in each of women's experiences. As a result, it was determined that being Controlled or Judged was not a theme that was universally present. The significant sense of stress and anxiety that surrounded the feelings of being controlled and judged led to the decision to incorporate it into the theme Overwhelmed and Stressed.

Highlighted portions of the texts were once more examined in an attempt to discover what the women were saying about the essence or meaning of living with postpartum depression symptoms. During this part of the process I questioned the theme of Hopes and Dreams. All of the women had some hopes and dreams for the future but

the presence of the theme was not as pervasive in the texts as were the other themes. After a dialogue with the nurse phenomenologist it was agreed that Hopes and Dreams should be kept as a theme because it was common to all of the women in the study. This theme is of particular interest because it was not a finding reported in other qualitative studies by Beck (1992, 1993), Chan, Levy, Chung, and Lee (2002), Leung, Arthur, and Martinson (2005), or Ugarriza (2002).

The differences between Abandoned and Isolated were again questioned and debated. Dictionaries, thesauri, and the literature were consulted and the themes of abandoned, isolated, geographic isolation, and remote were compared. The term geographic isolation was used by some in the literature to describe being a physical distance from others or from centers of population. It was found, however, to be more frequently used in discussions related to speciation. The term remote was considered and, although it described the separation piece of isolation, it lacked the emotional component of the experience as it was described by the mothers in this study. Furthermore, the reference to a lack of friendliness that is found among the definitions of remote made it an unacceptable choice of terms for this experience. The difficulty in selecting a term that would appropriately describe the experience of isolation and what it meant to these young mothers led to my decision to return to the study participants to solicit their help. The design of the research project included three rounds of interviews with the participants and the challenge presented by the theme of Isolation made this an appropriate time for the third round of interviews.

Seven of the ten women who participated in this study were contacted and arrangements were made to meet with each of them. I was not able to contact the

remaining three. During this third round of interviews all seven of the women strongly agreed that Abandoned and Isolated were two very different pieces of their experience. They said this spontaneously and with a lot of conviction. As a part of this third round of interviews, I asked each of the women for suggestions regarding an alternate word or way to describe what was going on with the isolation piece. Three of the women spontaneously suggested the word "stuck." When asked to talk about that choice of a word they said that they not only felt isolated from people, places, and things but they also felt that they were often just "stuck" in their communities or their homes because they could not get out and they were not able to go anywhere. It is as if a force was holding them back. One of the mothers said she felt like she was "in a bubble" and could not get out or go anywhere. All seven women agreed with the choice of the word "stuck".

After the interviews I returned to the transcripts of the first two rounds interviews and searched for the presence of the term "stuck." Two of the women used the term stuck in the earlier interviews to describe the experience or theme being referred to as "isolation." One of these two women was a participant I had not been able to include in the third round of interviews and one was among the three women who suggested the term "stuck." In these earlier interviews one of the women was talking about being stuck in a small town with no opportunity for employment and said that, even for those who were employed, there was no opportunity for a decent income. She talked about being "stuck in this town." The other context in which "stuck" was used in an earlier interview was a participant's description of her experience of being without a car for awhile and how it added to her overall feeling of depression. She said "stuck here. I mean I was here all of the time" (Gretchen, Interview #2).

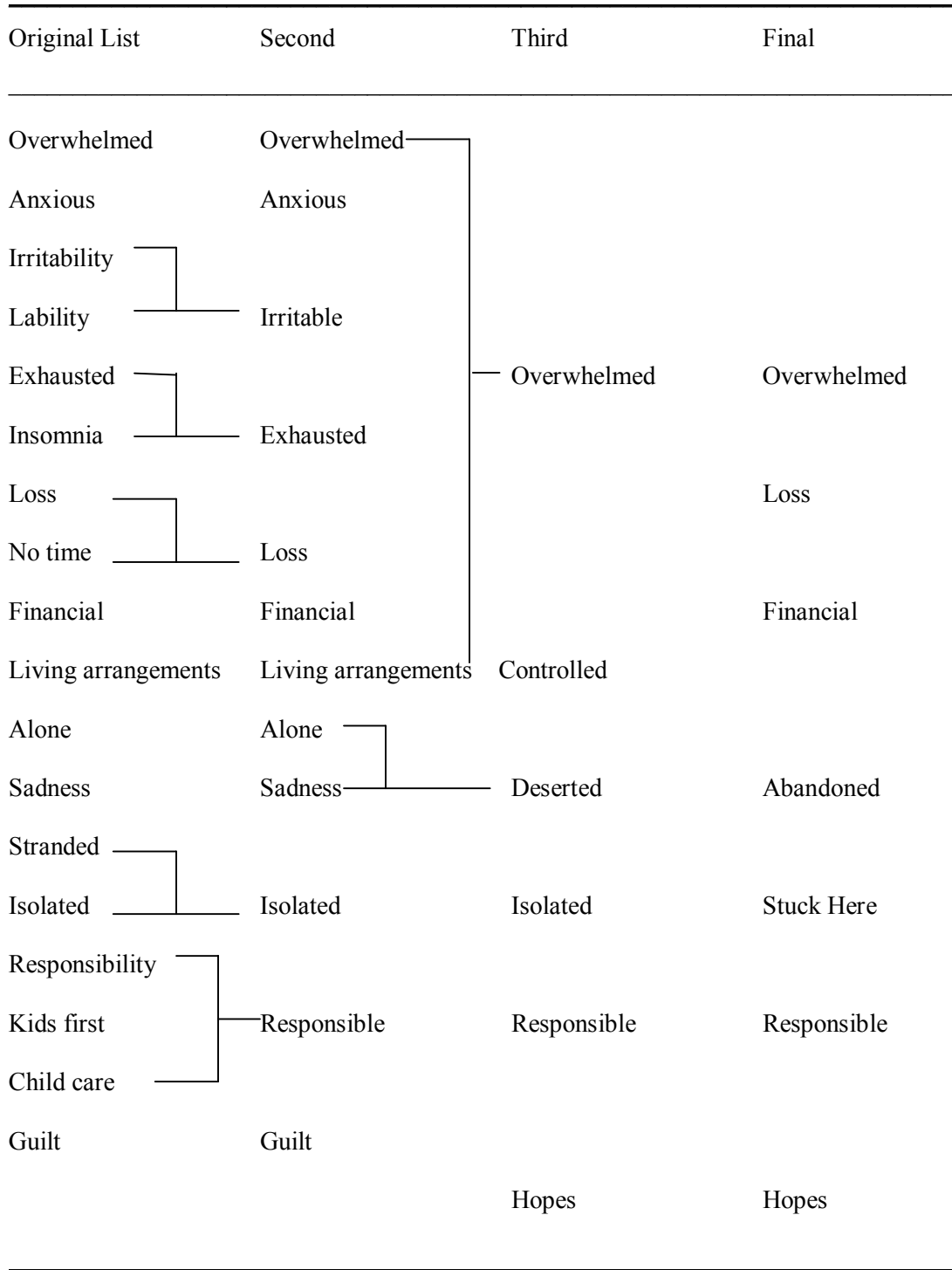
Following the interviews, the phrase Stuck Here was determined to be the best fit of terms for this theme. All of the women in the study felt they were stuck but how and where they were stuck differed somewhat among the women. Some of the women were stuck living in someone else's home or in a remote area; some were stuck in a place with virtually no job opportunities, dead end jobs, or a situation that prevented them from getting ahead financially or educationally; and some were stuck in their homes or communities and away from friends as well as goods and services. The phrase Stuck Here was mutually accepted by these women as an appropriate choice for the meaning of the experience that these mothers described in their interviews.

The women agreed with all of the remaining themes and there was nothing that they identified as missing or that should be added or changed. Each of the women, in this third round of interviews, indicated that the themes and overall meaning of the experience reflected the experience of postpartum depression symptoms as they lived it. The development of themes is outlined in Figure 1. The final list of seven themes included:

- Overwhelmed and Stressed
- Loss
- Financial Concerns
- Abandoned and Alone
- Stuck Here
- Fiercely Responsible
- Hopes and Dreams

Figure 1

Theme Development



It is important to remember that van Manen (1990) cautions the reader that themes are not important in and of themselves; they are only constructs to help us make sense of the experience being studied. Themes provide the structure needed to understand the phenomenon (van Manen, 1990). These themes can be either incidental or essential themes and it is important to be able to differentiate between the two. Essential themes are universal and without them the phenomenon or experience would not exist (van Manen, 1990). Questioning whether a phenomenon would be the same if a particular theme was absent helps to determine if it is an essential theme (van Manen, 1990). In the present process of analysis I attempted to imagine or picture the experience of postpartum depression symptoms without each of the themes. This was done for all seven of the themes. The question was asked: "Is it possible to experience postpartum depression symptoms without the feeling of being Overwhelmed and Stressed?" The answer to this question was that it was unlikely that the phenomenon of postpartum depression symptoms would remain essentially unchanged without the experience of being Overwhelmed and Stressed so it was determined that it was an essential theme. The same questioning was used for each of the remaining themes and it was concluded that the themes of Loss, Financial Concerns, Abandoned and Alone, and Fiercely Responsible were all essential themes; without these themes the experience of postpartum depression symptoms would not exist as these women lived it. These themes are so interwoven throughout the women's experiences and so essential to the meaning of the postpartum depression symptoms for them that the themes cannot be removed and have the experience remain essentially the same. When the same question was asked of the themes Stuck Here and Hopes and Dreams the answer was: yes these experiences can be

removed from the experience of postpartum depression symptoms in these women and the experience would still exist and would remain largely unchanged. These two themes, while common to all of the women in the study, were determined to be incidental themes.

It is interesting to note here that during the third round of interviews I asked each woman if I was correct, in my understanding from earlier interviews, that she had some hopes and dreams for the future. All of them answered in the affirmative. Two of the women qualified their responses by saying that they had hopes and dreams but that they were small ones at this time. Another woman said she had hopes and dreams but, while she continued to hope for the best outcomes, she expected the worse as a way of minimizing the disappointment if her hopes and dreams were not realized.

#### Prologue to the Stories

The women in the study were interviewed in the format of a conversation that occurred within the context of a visit. The initial conversation occurred as part of the process of determining eligibility and obtaining written informed consent. This first conversation was not audio taped. Comments made by the women during this conversation were used only to determine eligibility for inclusion in the study and as individualized semi-structured interview guides for each of the first taped interviews.

During the first interview, the initial question asked, with some variation, was “What has it been like for you since your baby was born?” The words differed but the answers bore many similarities. All of the women indicated that the experience had been a very difficult and stressful one. Some of the words they used to describe their experiences included: “hectic”, “horrible”, “awful”, “really stressful”, “overwhelmed”, and “hell.” For these women their greatest stresses, since the birth of their babies, were



the never ending responsibilities for relationships, children, finances, and household chores such as cooking, cleaning, and laundry as well as significant financial concerns and a sense of loss. The women who participated also told of being, in some way, deserted or abandoned by those they believed would be there to provide support as they learned to adjust to life with a new baby. The geography and economic conditions of the area made it difficult and stressful for the women to gain access to jobs, goods, services, leisure activities, and often family and friends; it made them feel stuck in their current place or situation. Surprisingly, all of the women maintained at least a faint glimmer of hope for the future. Each of the women interviewed demonstrated a strong belief that their primary responsibility was the well-being of their children and each was steadfastly determined to live up to that responsibility. Seven themes emerged from these interviews: Overwhelmed and Stressed, Financial Concerns, Abandoned and Alone, Stuck Here, Fiercely Responsible, Loss, and Hopes and Dreams.

### The Women's Stories

#### *Overwhelmed and Stressed*

All of the women in the study expressed some level of stress and all were overwhelmed by the postpartum experience. Stress is defined as “a state of mental or emotional strain or tension resulting from adverse or very demanding circumstances” (Oxford, 2001, p. 1285). Being overwhelmed results from the “strong emotional effect” of someone or something and leaves the person who is overwhelmed feeling that the demands are “too strong” for them to bear (Oxford, 2001, p.1222). The stress that is related to childbirth, and that often overwhelms women, results from a myriad of adjustments that must be simultaneously made by postpartum women as they adapt to the

physical, emotional, and social changes that accompany the birth of a baby. For all of the women in this study, stress was emotionally disruptive and, for at least one of the women, it included physical symptoms. It was as though the very structure of their lives had been rearranged; nothing was as it had been. For some, these feelings began during a previous pregnancy and continued into the present pregnancy and postpartum, for others it began during pregnancy, and for some it only began after the birth of this baby. They felt that, no matter how hard they tried, they could not attend to everything that needed their attention; they felt pulled in many different directions and with no end in sight.

The women in this study used the terms: “irritable”, “stressed”, “horrible”, “stunned”, “angry”, “edgy”, “blow-up”, “explode”, “aggravated”, and “hell” to describe the way they felt. The stresses these new mothers experienced in their everyday lives were so strong at times that they were overwhelmed by them. As Sofie said during our first interview, “you got so much pressure it gets in the way and you just don’t want to do nothing.” Wendy expressed it similarly when she said, “You’re so overwhelmed with everyone it just knocks you down.” (Interview #1) Some of the women talked about their inability to sleep because of the stress and worries they were experiencing and others talked about being exhausted and wanting to sleep all the time; all of them were stressed and overwhelmed by the postpartum experience.

Sofie is a single mother of four. She is estranged from the father of her younger children and has been left alone to provide for them. Sofie and the children live in the home of a relative who is disabled and unable to provide much help but she said she knows that he would never allow her children to “go without.” She described the experience of having to work as well as to care for her children, the laundry, house, and

cooking as “horrible.” She said “it was okay” when she first returned to work but then it got progressively worse. She was getting only 4 to 5 hours of sleep a night and was “really having a rough time.” She said:

It’s like I just can’t get nothing done and everything just piles up on you. The faster you get something done the faster something else piles back up on you, you know. Like, god, you know? I probably get way overwhelmed with all this work and pressure.... Your work needs your full attention and your kids need your full attention. You know, you’re just like pulling. It’s like one’s going one way pulling the other, you know....nerves, aggravation, it all just combines at one time and you just want to go POW. Just explode everywhere (Sofie, Interview #1).

At the time of our first interview Sofie had only recently become unemployed and had hopes that the feeling of being so totally overwhelmed by her life would improve. She was full of life and there were squeals of laughter that could be heard from her driveway as she played with her toddler. At the time of our second interview her mood was much more somber and her hopes not so high. When asked about it, she said things were “a little better” since she had stopped working but the emphasis was on “little.”

Elaine is quiet and not as articulate as the other women and she is one of the youngest participants. She is stressed by her baby’s crying and the fact that she cannot always find a way to successfully comfort him. Elaine very quietly and somberly described her experience by saying:

Well, I felt down and depressed and always wanting to cry but it’s not just him. I mean, um, sometimes I do get aggravated, and I don’t know, he’s so young and I don’t know what’s going on. I try a lot of stuff and everything and he just wants

to cry.... When he was born I was all right. I didn't have much problem with him cuz he slept almost all the time and he hardly ever cried. Now that he's gotten bigger that's practically all he wants to do is cry (Interview #1).

Rebecca, her fiancé (the father of her baby), and her two children live in a small home with her parents. She described her experience as:

Hectic, hectic, stressful but happy at the same time but somehow my money situation's all different now. We're one, now we're two and [chuckles] you know, but it's, well my main thing I want to say is stressful and that's it (Interview #1).

Their home is crowded and there is little privacy. Most of the household responsibilities, including cooking, cleaning, and bill paying, fall on her shoulders. In addition, she said, her parents also expect her to fund some expenses that she sees as extraneous. When Rebecca is able to have a little money saved her parents demand it for something they want. This situation is not specific to Rebecca but is similar to the one Wendy, her husband, and two children were in when she enrolled in this study.

The stress often made it difficult for Rebecca to fall asleep at night even after the baby was sleeping. She said:

I've caught myself at nighttime when the baby is sleeping and I'm laying there and my mind's going 90 miles an hour and won't shut down.... I just lay there and you know, go to sleep, he's sleeping, baby's sleeping, it's time to go to sleep and then I just lay there and I just think about anything that happened that day or what bills that need to be paid or this or this or (Rebecca, Interview #1).

Rebecca was also exhibiting some physical symptoms of stress and anxiety. She said:

If I'm all like stressed out and really there's nothing to be stressed out about and I, my stomach, I'll be in knots and feel like I'm gonna get sick and my head is pounding and stressing out.... I get like the shakes. Sometimes I feel my heart's pounding like I'm going to have a heart attack (Rebecca, Interview #1).

For Tammy, a mother of three, her stresses were compounded by the fact that her five year old has been diagnosed with autism. When she described her postpartum experience she said:

It's really hectic. I get to the point sometimes where I'm not sure if I can do it or not, you know, like getting up in the middle of the night and feeding him because I'm so tired sometimes I don't remember feeding him. I know that sounds bad but I know he's fed because if he wasn't he'd still be screaming at me.... It's really rough around here sometime, just my nerves get wrecked cuz I got kids screaming and hollering and I got three different kids pulling me in different directions cuz one wants to eat or one wants their butt changed or one wants to go outside.... Sometimes I cry; just sit down and cry (Tammy, Interview #1).

Tammy said she also has days when she is moody and irritable for no real reason. Some days, I don't know, you know what it is, I'm just, I guess I'm, I'm mad at the whole world for no apparent reason. I mean nobody has to do anything to me or say anything to me. I just wake up in a grouchy mood and. I don't know, sometimes I feel like the whole world just irritates me no matter what happens .... I don't understand why I do it (Tammy, Interview #1).

Lauren is a first time mother who is estranged from her baby's father and currently living with her parents. The living arrangements are stressful and she is looking forward to finding a place of her own. When asked about her experience as a new mother Lauren said:

I was pretty much stunned by the situation; here's your kid, take care of him.... It comes to a point that feeling overwhelmed and having to worry just about him that, yeah, I went, you know, days without realizing that I haven't ate or I haven't taken any time to sit down and just get my thoughts together or taking a shower worrying about pleasing him (Lauren, Interview #1).

Wendy, her husband, and their two children have recently moved into their own place and she said it has relieved the stress that was related to their living arrangements.

Wendy said:

Yeah, it's not as much stress as with my mom and dad. Yeah, I ain't so overwhelmed worrying about what they're gonna say, what they're gonna do, if I'm not doing the right thing, if I have something they want. Every time I had money saved they wanted it. I was tired of it; it didn't work....Living there [in her parent's home] was like living in hell (Wendy, Interview #1).

When Wendy described her postpartum experience she said, "You're so overwhelmed with everything it just, oh, it just knocks you down, you know. [It's] sort of like you can't even take a bath anymore without having them right there. You can't do anything without having them attached" (Interview #1).

Gretchen lives with her boyfriend (the father of her children) and their two children. When she was asked about her postpartum experience she said:

With both of my kids it was awful. Their dad is an alcoholic, he's been a drug addict and whenever I was pregnant with [older son] he would take our money for food and go spend it on drugs, he had his alcohol, and he was violent and very abusive mentally, physically, and emotionally (Gretchen, Interview #1).

About the present, she said that since the birth of her baby, "it's just, you know, too much sometimes." When Gretchen was asked to summarize her postpartum experience she spontaneously responded: "Hell." After a brief pause to give it some more thought she added "That would be the best I would know how to describe it" (Interview #1).

Martha, whose relationship with her baby's father recently ended, had a lot to say about her experiences since becoming a mother. For Martha, her postpartum experience was somewhat different than the others. About two and a half weeks after her baby was born, she was admitted to the hospital with a potentially life threatening postpartum complication. At about the same time her boyfriend, the father of her child, moved out of the home they shared. When she described her postpartum experience she said:

Well, it wasn't. I mean like I said, it wasn't all him [baby]. I would try to do things to please his dad.... I'd get frustrated with it because you know I had stitches and I had an episiotomy from almost past my butt hole and I was trying to get out of bed with that and wearing two pads and stretch panties and ice packs down stairs for quite awhile when I came home. It wasn't at all easy getting around so it was overwhelming....I had to take care of him [baby] and I had to take care of [boyfriend] and then, then myself came last and I really needed to be

able to take care of myself cuz I was really bad off. I couldn't move hardly but I still managed (Martha, Interview #1).

Elizabeth is a young mother of three who is no longer with the father of her children. Her description of her postpartum experience was more concise than some. She described it saying, "It's hard, it's frustrating, it's nerve-racking, and sometimes I feel like I can't do it and sometimes I feel like somebody else could do better but other than that it's just, it's rough sometimes" (Interview #1). She also said "I feel crazy" and "I cry all the time or feel like I'm gonna cry." Elizabeth said that at other times she felt like she was just going to "blow up." She said:

It is hard. Its money and time; being able to, whenever you're off work you know, and sometimes I just feel like going into a room and locking myself in there and never come out. But I don't because if I give up on my kids there wouldn't be anybody to take care of them, you know (Elizabeth, Interview #1).

Patricia is a first time mother who lives with her husband and her mother. When asked about her postpartum experience she said, "You feel like you're responsible for everything." In that everything she included the baby, laundry, finding childcare, cooking, cleaning, and caring for the animals. In addition to feeling responsible for everything, she said, "I don't feel good about my outward appearance [she has psoriasis]; I feel pressured being the sole provider as far as me and the baby.... I'm scared for my job because of the financial issues of the corporation" (Patricia, Interview #1).

Patricia's baby is experiencing significant gastric reflux and the resulting slow weight gain. In addition to worrying about the baby and dealing with the endless clean-ups and loads of laundry, she is frustrated, angry, and fearful because of her interactions



with the personnel at the Women, Infants, and Children (WIC) clinic. She said that they continue to question and reprimand her regarding her baby's slow weight gain.

This young mother has made the 140 mile round trip to take her baby to the nearest pediatrician and been medically compliant but remains concerned because the Women Infants and Children program employees have, in her words continued "gnawing at my back bone" and that "it concerns me that WIC will turn me in, you know. And it's not gonna to be pretty if someone from DFS shows up at my door." She said she fears losing her child because of "someone's stupidity" (Patricia, Interview #1).

What Patricia said near the end of our second interview is one of the defining statements regarding the feeling of being overwhelmed and, at least in part, the support that is needed to survive the moment. She said, "I know I can depend on my mom. It kills me to ask her. So she's gotten to where, she's gotten to where if she sees I'm having issues she'll pick him up and run off with him... literally." Her mother was in the home at the time and chuckled softly when she heard the comment. She knows that this is a small but very important thing for her daughter and for any other new mother. It is knowing that someone can see that you have reached the point of feeling like your head is about to slip beneath the surface of the water and that person reaches out to lift you up, albeit briefly, and allows you to catch your breath. More importantly, it lets you know that there is someone there who will keep you from going under and remaining submerged.

### *Loss*

The lives of all women are significantly changed when they become mothers and all experience some sense of loss which is "the fact or process of losing something or

someone” (Jewell & Abate, 2001 p. 1009). This sense of loss was present in each woman’s description of her postpartum experience. Each had experienced the loss of some part of her life that existed prior to the birth of her infant. Among the losses that new mothers experienced were the loss of: the companionship of friends they had before they became parents, control over their emotions, a relationship they had or expected to have with the father of their child, freedom from 24 hour responsibility for another life, time to be with friends, time to be alone, or time to go out and do something for themselves. Some of the women described a loss of their own independent identity and the assumption of an identity that was defined only through their relationship with their children. Each of these women experienced a loss of time for self, which at times, became overwhelming and interfered with her ability to find a space in which she could attend to basic necessities like sleeping, eating, or showering. As one mother said, “Nope! Not even bathroom time. I go to the bathroom and, like, one of them’s coming in there on me. [Baby]’s gotta take a bath with me.” (Sofie, Interview #1).

With some degree of sadness, frustration, and resignation Sofie also said, “I would like to get out and just be able to play a game of something all night long and not have to worry you know. But, that probably will never happen.” She then clarified this a little by saying “without, just by yourself and just like maybe just go play a game of pool, a video game, you know, or go bowling or just something. (Sofie, Interview #2).

For some of the women it was the loss of a relationship that they had with the father of their child; for other women, it was the loss of the person or self they had been; and, for some, it was the loss of the opportunity to delight in their youth and all that goes with it. In the words of two of the women, “I’ve lost all my friends I, I just, I really ain’t

lost everything but I just don't have the friends that I had" (Elaine, Interview #1) and "I don't feel like I have a life anymore" (Gretchen, Interview #2).

Five of the women began parenting prior to finishing high school. They all talked about the loss of their friends and the ability to just go out and not have to worry about their children. None of them talked about a desire to be without their children but they did yearn for the opportunity of go out and be with their friends occasionally. Rebecca expressed this when she said:

I'd just like escape. I'd like go somewhere and if it wasn't for, you know [her children], I would, honestly. I just would want to leave, you know, for a few days. Just go up to where I used to live, where all my friends are that I grew up with whatever but then again I got my kids (Rebecca, Interview #2).

Tammy talks about what she missed by becoming a mother at a very young age. She said:

There's times that I just kind of wish that I would have waited to have kids so that way I could've still went out and done things with my friends.... I don't feel trapped, I just feel, I feel like if I could just get out for awhile, just to go out and just be kind of carefree there for a while, just for a little while it would make things go a lot easier at home. I mean, I don't know, um, but like I said if I do I feel guilty so (Tammy, Interview #1).

For Elizabeth, it was not only having children at a very young age but also having to work all the time that kept her from experiencing the freedom and joys that others her age were experiencing. Elizabeth worked, parented, and completed high school simultaneously. She said:

I guess being so young and having to work all the time and miss out on your friends [tearful] and it's really hard being by yourself. I mean, I guess when you're by yourself you don't have really anybody to talk to (Elizabeth, Interview #1)

Lauren and Wendy expressed their feelings related to a sense of loss of their own individual identity and of being recognized as someone's mother rather than as themselves. Lauren said:

I'm glad that everyone loves him and it's kind of odd to sit there and just be jealous of your own kid when you now sit in the background and people forget to say bye to you but they'll say bye to the baby and [said with a slight laugh]. I've gotten pretty much used to it now and it really doesn't faze me when people will do it but at the beginning it really rattled my nerves because I'm sitting there thinking OK you just talk to me every day and come see me to see what I'm doing and now that, you know, the baby's here then I'm completely different, I don't exist. Basically, I'm just his mom (Lauren, Interview #1).

About her experience, Wendy said:

Before I was me now I'm wife and mother, that's it. I'm not Wendy no more, I'm mom, I'm the wife, I deal with it, everything in the house, the kids, run for the kids, I do everything. But people don't even ask me no more, "How are you doing?" They say, "Oh. how's your kids doing?" One of my friends said, "How's the kids?" They're fine. Like my birthday's coming up and my friend, her birthday is the 27<sup>th</sup> and so oh you want to go to town. I said I can't, I have kids. She said, "We're all going go see a movie up there." I can't. I can't take them

with me, I can't go so. All my friends are going, I don't get to go. So that kind of threw out all. And then like ever since I had kids I have a birthday party. I get a babysitter sometimes and I have a birthday party and nobody comes. None of my friends come cuz like, "You didn't come to mine." I'm like, "Well I have two kids. It's not easy for me to come every time you say hey, let's go." (Wendy, Interview #1)

Gretchen talked about the loss of the relationship she had with the father of her children before she became pregnant with her their first child; the change was sudden and dramatic. Gretchen said:

Before I ever got pregnant we never fought, I mean, you know. We were best friends and we done everything together. We rarely fought, you know, he was so much more considerate, kind, caring, sweet. And then as soon as I found out I was pregnant with him [2 year old] that all changed. I mean just like over night.... You know, I mean it's like having kids has just messed everything up, you know (Gretchen, Interview #2).

For Martha, it was an event that ended a relationship that had already begun to falter. Martha said: "Everybody told me that it'd [having a child together] bring me and [baby's father] closer, you know. It just brought us apart." In addition to this loss of the relationship with her boyfriend, Martha lost the home that she had put a lot of time, effort, and money into because she could no longer afford to keep it. She feels, too, the loss of any time for herself and said "I want to have a little time for myself and I don't" (Interview #1).

*Financial Concerns:*

Financial concerns were a big part of each woman's description of her postpartum experience and they were interwoven throughout the other themes as well. For many women in rural areas and for all of the women in this study, their financial resources were very limited. The concerns about finances trigger feelings of anxiety, worry, and regret for new mothers who are trying to cope with all of the demands associated with having a new baby. For most women, the financial concerns centered around three key issues: budgeting, difficulties finding a job that was steady and paid a decent wage, and a sense of regret that they could not provide better for their children. They all wanted to be able to provide their children with more than the bare necessities of life. In addition to these struggles, the women felt that they were sometimes treated like second class citizens because they could not afford better things for their children. To the people who judged them, Patricia said: "Don't always judge a book by its cover; read it a little bit. You know, just because that kid's running around grubby it doesn't mean that they're not cared for" (Interview #2).

Budgeting was difficult for these women and often there was not enough money for basics; unexpected difficulties or needs often created financial burdens that seemed insurmountable at times. This was the case for one family when they needed auto repairs. They needed a working vehicle to continue getting to and from work but the only way they could make the repairs needed to keep their vehicle running was to use the money they had budgeted for their monthly bills. The financial concerns of these women were further amplified by the fact that there are few job opportunities in the area and those jobs that are available pay very little and have few if any benefits such as health

insurance. These young mothers know that they are meeting basic needs but they would like to be able to do more for their children; at this moment in their lives they are not able to accomplish this.

Elaine's husband has a steady job and they are living in a place of their own but are struggling. She said:

Well, we don't have much money to spare and I'd like to have more and give him more than what he has and I see all these people, all these kids out here with nice clothes and everything. I don't have the money for all that. And they think they're high and mighty and everything. It makes me sit down in a corner and just want to cry because they treat me dirty.... I'm proud of what I do got for him and the only thing that really counts is that he's got a roof over his head and he's got a vehicle to be transferred to the doctor and back and he's got clothes to put on his back. It doesn't matter if they're perfect or anything, it's just that he's got it (Elaine, Interview #1).

It was not just the financial responsibilities associated with the arrival of a new baby but it was the addition of one more stress to the already present feeling of being overwhelmed and one more problem that would have to be solved that made this so difficult for these mothers. Not only were these women faced with the responsibility of finding a way to solve the financial problems but they had to do it knowing that they were often not the ones who created, triggered, or escalated the problem by increasing the family spending, decreasing the income, or both.

Rebecca talked about some of her frustrations related to their financial situation.

She said:

He's [baby's father] got all kinds of fines. He's got all kinds of bills that are his bills but since we're together they're both of our bills. You know, he had a little led foot there for awhile. Speeding ticket, he had to get a lawyer, now we're paying a thousand dollar fine so they wouldn't take his license away. He's got lawyers' fees; he's got court judgments against him....I mean he has, you know like I said, his child support and he's got court judgments cuz his ex-wife's dad sued him for something and he lost and so he's got this judgment we're paying on him. All these things racked up not, and that's not, you know, nothing of mine. I have a phone bill, my cell phone bill (Rebecca, Interview #1).

Patricia's husband was working in the kitchen at a residential summer camp at the time of our first interview. This was not a permanent job and he had been told by his employer to "find another job." Patricia was concerned about him actually finding a job because she said he is not "a very work oriented person" and grew up in a family with a mom who worked and a father who "worked but not very hard and not very long either" (Interview #1). At the time of our second interview he had found a steady job but Patricia said that he expects the money he makes to be his while her income is used to pay bills and household expenses. She said that a request she made of her husband for help with the bills was met with: "Well what about me having money in my pocket?" (Interview #2)

There are few jobs in the area and many residents have to commute a great distance to find employment. The scarcity of jobs and the distance that must be traveled



each day place a financial burden on employment for many in the area. Those who work need vehicles, upkeep on their vehicles, and gasoline to fuel them.

Martha is currently employed in her community but because of her medical condition she needs to find a job with different physical requirements than the one she now has. She has responded to posted vacancies and submitted applications but has found nothing. She said:

I even went up to the work force place and everything and didn't get nothing.... They even sent me a letter saying I didn't qualify for anything they have. I was like, well how can that be? I've had just about every class that you can think of. You know, business law, business management, teacher's aide.... They ask if you know how to use a computer, what programs and I just about know every program that you can take and mess with on a computer (Martha, Interview #2).

Martha's financial concerns give her cause to question if she is the best parent to care for her child. She said:

You know, I just wonder from one day to the next if I'm going to be able to afford keeping a roof over his head, keeping him in diapers and all of that and I, I just try so hard to keep working.... You just wonder if you're doing the right thing. I'm not gonna, I'm always gonna have to be working. Working, working, working, working, you know, keep a house above him, make sure he has food (Interview #2).

Patricia and her husband have been able to find work closer to home but she is concerned because the corporation she is working for is presently having financial difficulties and their future is somewhat uncertain. She describes her situation saying:

It is scary not knowing. Not knowing is like being suspended in air. You can't see what you're being held up with. It's not fun cuz you don't know if you're gonna... fall through or if you're gonna be pulled back over to the left, you know? It makes me scared for [the baby], you know? But I'd do anything short of killing somebody or stealing to give him what he needs (Interview #1).

Transportation issues often compound the financial difficulties. It is not always easy for families to find a vehicle they can afford and to keep it in working order. The vehicles are often old and in need of repair when they are acquired. For Wendy and her husband they were having difficulties because their car was old and in need of a significant amount of work. Wendy said:

The motor's going out, transmission's going out, bad wiring problem, we have no tail lights or dash lights and something died in my car. We left the windows down and you know how bad animals are, right? I don't know, I mean that car unless we fix, it's, it's horrible....Everybody wants the money up front....He [husband] got a better job though it's great. He makes about \$400 a week. It's great now, better than \$150 like he was making (Interview #1).

For some families it is a conundrum: without the vehicle I have no income and without the income I will have no working vehicle? Patricia and her family faced this problem:

Financially it was draining because we had that money to pay for something else, for bills... and, um, it can be used for our vehicles and then these people call wanting their money and I'm like I can't give it to you. I have to have my car running so I can to get to work to give you money. "How can I give you what I

don't have?" I asked one of them that. "Well, Ma'am, we'll have to take you to court." I said "Then you'll get my three broken down vehicles cuz I don't own the house I live in, it's my mother's." "Well we can seize your accounts" and I told that lady on the phone, I said, "Honey I have forty dollars in my checking account. You go right ahead and take it. You want my 401K? I think it's worth twenty bucks." I said, "I have nothing [with the emphasis on the word nothing] to give you at this time" (Interview #1).

While it is difficult, Patricia said she manages because she does much of the service and repairs on their vehicles herself. Her dad was a mechanic and she learned by watching him work on cars. That way, she said, she needs only to come up with the cost of parts which is difficult enough.

Even for those who have jobs, transportation and distance often create difficulties. Elaine's husband works over and hour away from their home and Tammy's husband is a truck driver and away from home for long periods of time. Tammy's husband has recently been working locally to allow him to be home for the birth of the baby but he plans to return to his previous job after the winter months. His local job does not pay well and it does not provide health insurance and other benefits, Elizabeth has to commute to find work and she estimates that this is costing her over \$200 a month for gas (at 2006 gas prices). This estimate does not include the additional cost of gasoline needed to make the estimated 50-60 mile round trip for groceries, clothing, or trips to the physician for her or her children.

For women who must return to work after childbirth there is also the added responsibility of finding a child care setting that is a safe and secure place for their

child(ren). Most of the women in this study have had to rely primarily on family for childcare. For those who do not have relatives it does not always work out so well. Patricia said she had not been able to work more than a couple of days in the last few weeks because she was not able to make childcare arrangements that she was comfortable with. She said: "I've just worked twice since then [previous two weeks] because I don't have a sitter. There's no one, there's no one. Well there's lots of someones" (Interview #2). She had previously talked about all of the possible but unacceptable childcare arrangements and that she was not willing to leave her child with just anyone. For some women there are few options and this is especially true for those women without a means of transportation. Because Sofie does not drive, she had to settle for someone close and someone she thought she knew but it did not work out well for her or her children. She said:

I had a friend down the road watching my kids, which is another reason why I'm glad I quit work. She was watching these two [her two youngest children] while I was working and my son started doing things that I caught on to and I'm like, no this is not going to work. You know, it's just not going to work because they're teaching him things that I'm not gonna allow in my house in front of my kids, you know? My son does not know how to do those things unless he sees it. And it just went through me like a knife.... I wish that I could wait until one of these guys, my younger kids, went to school you know it wouldn't be so hard.... I'm hoping to be able to wait for a little while until I get my license at least that way, with a day job, I can put these guys in day care (Sofie, Interview #1).

The financial situation seems hopeless in many situations but these women just continue to put one foot in front of the other and do what they believe is necessary for the good of their children. Some of the comments that reflected this determination include: “I don’t buy nothing for myself probably at all. You know, I just think of my kids first” (Sofie, Interview #2); “It doesn’t matter if they’re perfect or anything, it’s just that he’s got it” (Elaine, Interview #1); and, “But I’d do anything short of killing somebody or stealing to give him what he needs” (Patricia, Interview #1).

### *Abandoned and Alone*

To abandon is to “cease to support or look after” (Jewell & Abate, 2001 p. 2). All of the women in this study expressed some feeling of loneliness and all felt, to some extent, abandoned by those on whom they thought they could rely for help and support. When the person they believed would support and care for them and their child did not meet that expectation there was a sense of abandonment. The feeling of abandonment was compounded when the child who was so important to them was ignored and abandoned by the other parent. These women were left alone to care for themselves and their children and to witness the rejection of their child by a parent. For some of the women, the abandonment was an actual physical abandonment by the father of their child(ren); for other women, the person on whom they thought they could depend for support or to share in the responsibilities of childcare was emotionally absent or otherwise unengaged in parenting or childcare. Whether it is actual physical abandonment or abandonment through the lack of engagement and support, the woman is left alone to parent and, in many instances, to provide financially for her child(ren). Several of the women said it felt like everything had been “dumped” on them or

“dumped” in their lap. Some of the women had the experience of being abandoned by the father of their baby and then witnessed him enter into a relationship with another woman and help care for her children or, for one mother, to father another child who would be only a few months younger than the child they shared. These women talked about the hurt that resulted from the situation. One of the women discussed the feeling that she had even been abandoned by her own mother when she talked about her mother’s unavailability. She said: “I went over there [to her mother’s] and knocked on her door; she wouldn’t even answer her door” (Gretchen, Interview #1). The aloneness that they experienced was, at least for some of the women, what they considered the greatest cause of their feelings of depression. Elizabeth said, “I think the most, the thing that depressed me most was knowing I had to do it on my own” (Interview #2) and Sofie said that being alone is “a horrible feeling.” Even for those women whose husbands were physically present, the feeling of having been emotionally abandoned by them was difficult. As Tammy said, “I feel like all the responsibility is on me even though he’s here.” These feelings were echoed by most of the other women who were still sharing a home with the father of their child. Patricia said: “Men act like it’s our responsibility to take care of their child and it’s not! We did not conceive this child on our own; we are not asexual creatures” (Patricia, Interview #2).

For Rebecca it was not the actual absence of her fiancé that caused the feeling of having been abandoned but his behaviors. She said “the main thing that really really gets to me is when I get the lack of help from him... I’m doing everything and he’s doing nothing.” She told him, “I’d rather do this by myself than have you around anymore because all we do is fight. It would be less stressful if I did it by myself cuz I’m still

doing it by myself' (Interview #1). She feels abandoned when he tells her that he will help and then does not follow through when she asks for his help. She gave the following example:

Well he'll tell me all the time, you know, well you give 'em a bath and I'll stay up with him, So, I'll do everything: get 'em to bed, give him his bath, get him to bed, you know, all that, get 'em to sleep. He [fiancé] goes to sleep, baby wakes up, he don't move, you know nothing and so again I'm up with the baby. Oh, I do that and he just like totally, like I'm not doing it. I kick him, yell in his ear, he'll look up at me and just roll back over. And me and him talked about it. You know, we had a fight. You know there was one morning he wanted to go hunting, I don't know what day it was and I told him to get out. Because, it was like I was up, I'd had like an hour of sleep, and I was exhausted. I was physically exhausted and mentally exhausted. The baby was up a lot. He had a real bad stuffy nose where he'd lay down and it was hard for him to breathe and he'd cry and... He [fiancé] would not get up at all to help me with the baby but when that alarm clock went off he was up, jumped, getting dressed to go hunting and I went off. I was like, you can get up to go hunting but you can't get up to help me with the baby?

(Rebecca, Interview #1).

Later in the same interview Rebecca said:

Everybody knows when you have babies you have a lot of stuff to do and it's like, you come home and, if I go to work, and you come home and bottles have to be cleaned, laundry has to be done, and I have to get both kids ready for bed and you know, give them a bath and by that time you're so exhausted and I want to lay

down and he [baby] wakes up and [fiancé] is asleep and the entire time I'm doing all this he was doing nothing, watching TV (Rebecca, Interview #1).

Gretchen and the father of her baby are also living together but she gets little help or support from him. She said:

It just hurts really bad because it seems like, you know, I'm doing what I'm supposed to be doing for my children to be a parent and it just seems like he's not, you know.... I mean if he decides that he wants to take off and drink that's just what he does. He'll pick up his stuff and he'll take off and then, you know, I just feel like everything has just kind of been. I know it's gonna be really a harsh way of putting it but it's like everything's been dumped in my lap, you know, I mean (Gretchen, Interview #1).

During the second interview she talked a little more about this feeling of being left alone to parent. She said:

I mean he just really made it hard on me, real hard. And then whenever, you know, he decides to take and go off on one of his drunk binges and take off for a week at a time and you know he's not the one that has to face, look at the disappointment on his [2 year old] face. He's not the one that has to hear him cry for his dad, you know. He's not the one that's left to pick up the pieces for the kids, to try to help them cope with everything and I don't think that's fair to them or me. And [boyfriend/children's father] just, he's a very, very, very selfish person. He's, he's only concerned for himself and that's it. It doesn't matter about us; it doesn't matter at all (Gretchen, Interview #2).



Patricia describes the feeling when she says: “It’s like you have this child dumped in your lap...” and she goes on to say:

I’m the only one who hears [baby] when he’s crying or I’m the only one who gets him and that hurts, that hurts, it does. You know, there’s times, there’s times I feel like [husband] drops him in my lap and runs. They still do their guy things; they still want to be free and they are free (Patricia, Interview #1).

Sofie is alone; the father of her two younger children is totally out of the picture.

What she had to say about being alone was particularly poignant. She said:

I mean alone like there’s nobody here to help me. Not alone like I have no company, you know. Because I’ve got company but I still feel lonely, you know, not nobody; I’m all by myself. I’ll be happy go lucky, you know, cleaning and everything and then it gets dark and like, I’m all alone and then I just sit down. I’ll be sitting down, watching TV, and eat all by myself” (Sofie, Interview #1).

Elizabeth’s mother is always there to lend a hand but the father of Elizabeth’s three children is not. She said she was “terrified” when she discovered she was pregnant the second time because she knew she would again be left alone to parent. The father of Elizabeth’s children had demonstrated with their first child that he was no up to the task of parenting. She said:

He would take her [baby] and, I know this for a fact, he would tell me um, he would take her to the bedroom and lay her on the bed and let her scream and cry back there and she would throw up. She had acid reflux and she would projectile puke everywhere and there was puke on the bed one night and I said what, what’s that from, you know? And, [he said] “Well I had to bring her back here cuz I

couldn't stand it anymore". You know, and I cried for my mom and I was like I want you to watch [baby] for me. You know, if he doesn't want to work and he's incapable of taking care of his babies while I'm at work (Elizabeth, Interview #2).

Elizabeth also described a moment of panic with her second pregnancy with the following:

I went back [to the doctor] a day before I graduated and he's like, "well, there's one of them." I said what do you mean there's one of them? There better be only one in there. And he said, "Well there's the other one." And my mom was sitting there and she said "I knew I seen another one" and I just started bawling 'cuz I was like, I knew I had to raise them on my own. 'Cuz I raised her [their first child] on my own. And then... Like a few weeks later, you know, I had to move back here [her mother's home] and, 'cuz he lost his job. He didn't go to work and he got fired. So, I knew I had to do it on my own and that's why I was crying because I was terrified. I didn't know how I was going to do it. (Elizabeth, Interview #2)

In Martha's case it was initially emotional abandonment but shortly became physical abandonment. There was a lack of help and responsibility when the baby's father was there and this was followed by actual abandonment when the baby was two or three weeks old. Like the other women in this study, Martha also felt that she had been left with the responsibility of parenting her infant and keeping his father happy. She gives the following example:

He [father of her child] said wake me up, let me know if you need any help and I'd wake him up two or three times and after awhile I'd get frustrated with it .... I

tried to get him where he [baby] was up when his dad was, before his dad went to work, and I tried to have him awake before his dad come home. That way he could spend time with him and everything and he'd spend time with him up until the time he went to go to bed. And he's say, well "I gotta go and get up the next morning" and "I gotta go to work, I need my rest" and this is how it was from the time I got out of the hospital until the time I got back in the hospital with blood clots. I didn't bother waking him up anymore because I knew how it would be; he'd just fall back to sleep....When I went to the hospital because I couldn't walk I was in so much pain, he told me I didn't need to go. He said my doctor said that everything would be all right in a couple of weeks and I'd be all right just to get over it. And if it, if I had to go to the hospital to have someone take me because he was working that morning. [This was all spoken very softly.] You know, if you have anyone who loves you and supports you to the point of he wouldn't bother to tell you to have your family take you. That's when I realized that, when he didn't come up to St. Louis you know when I was in the hospital, that he doesn't really care (Martha, Interview #1)

What makes it feel so unbearable to these women is not only that they have been abandoned and left with all of the child care and parenting responsibility for their child but they have no one to talk to or with whom to share their lives and, more importantly, their children have been shunned and ignored.

Lauren said:

He still hasn't called, still hasn't come and seen him. He hasn't seen him since he was three weeks old now so and he's over two months. He's missing a lot but he's

about to have a second kid and he's not worried about his first one at all (Lauren, Interview #1).

Later in the same interview, she said:

It hurt really bad that he didn't want to be around and be a part of his son's life...I expected it for me to be put on the back burner but not him. I expected his dad to have a lot more to do with him than he does (Lauren, Interview #1).

When Elizabeth talked about the abandonment she said:

He should have to help me and want to help me not just because he has too but because. Maybe he should have been there, you know, helping me raise his kids... and ... he doesn't have anything to do with them really. He doesn't call or want to see them or talk to them, you know. I mean, it's all about him and I guess....

Whether he'd be there for you, you want him there for his kids.... He should be there for his kids no matter what, and he's not and I think that's really important. (Elizabeth, Interview #2).

Patricia and her husband are together but she still feels that, on some level, she and other women have been abandoned by their partners and left to bear the all of the family responsibilities. She said:

We [women] work our tails off but not inside the home, not just there, we do both, we do both. We're not just the wife, the mother, the housekeeper. We're now the wife, the mother, the housekeeper, the provider.... We're not doing it to keep the man happy we're doing it to survive, to make a life for our kids.... It's a matter of making sure your children have what they need (Patricia, Interview #2).

*Stuck Here*

There was a common feeling of being “stuck here.” The women did not all feel “stuck” in the same way or same place but all had the feeling that they were “stuck” or being held back in a particular place or situation. For some of the women, like Rebecca and Wendy, they were stuck in their parents homes and living conditions that, at times, felt almost intolerable. All of the women in the study felt stuck in a geographic location that isolated them from people, goods, or services, and some felt stuck in situations or locations that prevented them from acquiring a job or an education that would allow them to advance. The word stick is defined as “fixed in a particular position or unable to move or be moved” as well as “unable to progress with a task or find the answer or solution” (Jewell & Abate, 2001 p. 1672). This certainly describes what these women related in the interviews and, very aptly, the women themselves were the ones who suggested this description or interpretation of their experience.

One of the factors that contributed to these women feeling stuck was distance. For most of the women who participated in this study it is approximately a 90-140 mile round trip to their obstetrician’s or pediatrician’s office; most phone calls are long distance; there are no grocery stores in some communities; there are few job opportunities; there is no transportation other than private vehicles; and there are no post secondary schools in any of the counties included in this study. To put it into a perspective that most can understand, it is about an hour’s drive for many residents of these counties to get to a MacDonald’s or a Wal-Mart. Towns are small in this area with populations ranging from just over 100 to about 2,000 residents. Of the ten women who participated in this study only four of them lived in one of these small towns and the others lived several miles

from the nearest town of any size. Of the ten women, four did not drive and could not even get to the store for groceries without the assistance of friends, neighbors, or relatives. For Sofie, even the ability to get a job and take her children to a baby sitter to day care provider was problematic; she had to depend on others for transportation for everything. Despite having the skill and license to drive, the other six women did not all have access to a vehicle they trusted to make the average 100 mile round trip for goods and health care services. Some of the women were also isolated from their friends who often lived in a different communities and it required a vehicle to be able to visit with them or a long distance telephone call to speak with them. This all led to a feeling of being stuck where they were and unable to move forward; it was a feeling of being held back by some force.

When Wendy finally moved out of her parent's home and into a home of her own it was to an even more isolated area and she was unhappy and uneasy regarding the isolation and remoteness. She said she was "stuck" out there and said: "I haven't had anything to do here but to think" (Wendy, Interview #2). At the time of the third interview she had moved back into town but said she still felt "stuck" in her home. She described it as a feeling of being "stuck in a big bubble and all the air was being slowly sucked out of it" (Gretchen, Interview #3).

Sofie lives in a town with fewer than 200 residents. She can walk to a friend or neighbor's home but she is dependent on others for rides to the store for groceries or even to get to work. She is truly stuck where she is without help from others. Sofie said she is having difficulty getting an appointment with her physician to get her prescriptions. She missed her appointment because her daughter was ill and there is not another one

available for two to three months because the physician has few office hours in the town nearest to her. Because she depends on others for transportation, she can only see her physician on one of the few days a month that he has office hours in her area. She talks about the need for getting her driver's license and a car but has not been able to get either at this time. Sofie's only leisure activity is bingo; it is all there is to do in her town of 200 residents. She said: "Once in awhile my mom might pop for to keep 'em [children] for me to go play bingo for a couple of hours but, other than that, I'm out of luck" (Sofie, Interview #1).

Rebecca doesn't drive and her fiancé's driving style has put him in some danger of losing his driver's license. His license has already been suspended once and she said, "If he gets one more point he'll lose it for a year.... I told him with the baby now, especially with me not driving yet, we can't afford for him to lose his license" (Rebecca, Interview #1). Without his ability to drive he will not be able to work and they will have no means of transportation other than her parents, other relatives, or neighbors. They will not be able to get to the grocery store, the doctor's, or anywhere else. They live in a small compound that is in a rural area about 5-10 miles from the nearest town and there is absolutely nothing between their home and that town. They do not even have access to bread or milk unless family or neighbors take them into town. While they are pretty much physically isolated, except from family and neighbors who live in the same or a neighboring compound, she does have access to a computer and the internet which enables her to talk to a friend living in a different part of the country.

Rebecca talked about how much better she thinks it will be when she finally gets a driver's license and can say "Okay, kids, let's go somewhere; I'm tired of here [home]

and lets go. I can't deal with it and I know after I'm able to do that [drive] I think it's going to help a lot." She was studying for her written exam and has been practicing her driving but was very worried about driving on the local roads so she is making only slow progress with this. Rebecca was the passenger in a car that was involved in an accident with a fatality several years ago and admits that this is a large part of her slow progress. She said "I was doing okay before my accident.... It was after the accident." Rebecca talked about her feelings and said:

I know I can do it but I still have that panic like the first time I'm in the car with one of the kids or if I'm going around a curve, or if I'm going to panic you know. I still have all that cuz curves scare me a lot (Interview #1).

One of the big challenges is the distance to services. Tammy's daughter is not receiving the services she needs and that Tammy believed she was receiving at school. These are services that were included in her Individual Education Program and signed off on by Tammy and the officials at her daughter's school but services are scarce or do not exist at all in many rural areas. Tammy and all three of her children will now have to begin to commute two or three evenings a week to another community to get services such as Physical Therapy and Occupational Therapy that her daughter needs to continue to make progress. Making that drive several times a week with three children will not be easy and in the winter months, when the days are short and the roads are hazardous at times, it will be even more difficult. The long drive and the need to take all three of the children with her two or three days a week will only add to her stress and feeling of being totally overwhelmed. During the third interview, Tammy told me that they had to take their oldest child out of the school in her local school district and place her in a state day



school because the local school district remained unable to provide for her daughter's educational needs.

Elizabeth said she was giving thought to moving so she could be closer to her job, as well as goods and services. She thought this would save a significant amount of time currently spent on commuting and money spent on gasoline but, at the same time, she feels she can't make the move because her family helps with child care when she works and she would not be able to work without this help. She feels stuck and said:

I think, money wise, like to have to drive 30 to 45 miles to get to a real grocery store, like Wal-Mart, and money; yeah it's safer out here cuz like you don't have millions of strangers walking down the street watching your kids play. But money is tough, like when it comes to values um, I bet I spend like \$200 or so in gas, you know, and that's not monthly that is just like weeks you know and living so far away from people it's, it's hard to, you know, it's hard in a way to find a baby sitter like somebody outside your home or your family and it's hard to trust them to watch your kids and I get aggravated about that too because my mom can't watch my kids all the time, you know, and I know she gets tired of doing it and whenever I want to go do something I'm like, well if my mom can't do it I don't have a baby sitter, you know (Elizabeth, Interview #1).

Lauren has also given some thought to moving out of the area to a location where there are more opportunities but feels like she is stuck here because of her family. She said the following regarding her current place of residence:

Being able to have a means of being able to work and make some at least half way decent money; it's not here. I mean everyone here in this town is below

poverty level, I mean, and that's even the doctors who are stuck in town they're still at poverty level, there's nothing here, so. I'd rather be able to make something of myself and make sure he's [baby] provided and doesn't need anything or want for anything so. It definitely won't be here because there's nothing here and that's been proven widely over and over and over again (Lauren, Interview #1).

Gretchen lives in town and has neighbors nearby but she said she still has no one she can really talk to. Most of her friends are in a neighboring town and she is not able to see them anymore because of the distance and the difficulties of traveling with two small children and an unreliable vehicle. She said it makes it "not even worth going" because:

Whenever, you know, you don't have an air conditioner in the car you can't just pick your kids up, you know, in any kind of weather and you gotta make sure you have diapers and wipes and formula and bottles and every thing, you know, and it just gets to be too much so it's just not even worth going... you know (Gretchen, Interview #1).

Gretchen is also having difficulties with health care. She says she has not kept her last doctor's appointment because there is no one to care for her children and she does not trust her car to make the 100 mile round trip to her physician's office. She is also cut off from her friends because of distance and driving conditions. It is roughly a 40-50 mile round trip drive to her friends' homes and the road is one with a long history of motor vehicle accidents.

For all of the women, the driving conditions are often less than ideal. Many of the roads between communities are two lane highways with hills and an abundance of curves,

no shoulders, few places to pull over, and the occasional deer or other variety of wild life sharing the road. An additional concern for many in the area is that these highways, similar to the one Gretchen fears, have had more than their share of motor vehicle accidents and fatalities.

Jobs are few and Martha said she has been actively looking for one. She made application at a variety of places and has even been to the local work force office but has been unsuccessful. She is also looking forward and considering a move to a more urban area to provide her son with opportunities that are not available in her area. She said that other larger communities might offer him some of advantages she did not have growing up in a rural area. Martha said that she wants him to have “the best advantages in life.... That he can do better in his life than I’ve done in mine, then I’ll be happy” (Interview #1). Even activities such as track and football are not available at the local schools. Medical services are limited and when she developed deep vein thrombosis after delivery she had to be air lifted more than 150 miles for medical care.

Some of Patricia’s sense of isolation is somewhat self-imposed and related to her lack of trust in others, especially other women, but she said that, at this point in her life, she really feels the need to have someone to talk to. At the time of the first two interviews she said that there was no one with whom she could talk other than her mother and her husband and this was not a helpful situation. Patricia was not comfortable sharing some things with her mother and she did not think that her husband would have the same level of understanding that another woman and mother would have. At the time of our third interview she had found another woman with whom she had become friends and was comfortable discussing some of her challenges and difficulties as a new mother.

Patricia also had a feeling of being stuck in an area that provided few goods and services and made her life more difficult than it already was. She said:

Being able to provide for what you need in this area is not easy. Of course a descent store for me to get everything I need for him in one place is 75 miles each way. That made it hard too, having to make sure he has what he has on the budget that we have (Patricia, Interview #1).

Patricia displayed a lot of frustration when she talked about the lack of resources and services available to residents of her area as compared to those available to residents in more urban areas or even residents of her own community with greater financial means:

They have the opportunities; they have the resources within arm's reach or a phone call. Not here, it seems like the line stops at [names two neighboring counties], those two counties. It like stops! You know, we're not a bunch of cave men down here (Patricia, Interview #2).

Patricia also talks about her desire to attend college; one of her goals is to become a nurse. It is 70 miles to the nearest community college making this out of her reach at the present. She is considering online courses for now but hopes to be able to attend classes on campus some time in the near future.

### *Fiercely Responsible*

The New Oxford American Dictionary (Jewell & Abate, 2001) defines fiercely as “showing a heartfelt and powerful intensity” (p. 629). Being responsible is “having an obligation to do something or having control over or care for someone as a part of someone’s job or role” (Jewell & Abate, 2001). There is little question that this describes

the sense of responsibility felt and demonstrated by these women. They exhibited a strong sense of responsibility for the well being of their children and indicated that they would go to almost any means to protect them. They also revealed a feeling of responsibility toward others in their circles but it was always clear that their responsibilities to their own children came first.

Having children significantly changes women's lives in a variety of ways and adds a new set of stressors. These women were no different but what is interesting is the way in which they came to terms with their new lives and accepted their new responsibilities with such determination. Sofie expressed her willingness to live and parent alone if it meant that her home was a safer place for her children. Elizabeth and Sofie both spoke of the anguish and the tears that accompanied the realization that they were pregnant but they also both spoke of steadfastly accepting the responsibility, sometimes on a daily basis, of parenting the children they brought into the world and of being there for them. All of these mothers expressed and demonstrated a great deal of attachment to their children and thought they were, at least in some ways, a gift or a blessing.

Sofie described the distress she felt when she knew that she was pregnant with this baby. She said:

I was crying and screaming. I was like, oh my what am I going to do? Well, until I about said to myself: well, I guess I'm gonna just raise 'em just like I did the others, here we go! But I cried and I just cried and I just cried. I didn't with my other ones and you know what? Everybody's, like, you can give him to me, you know. No, I'll tell you what; I said, if I have a kid to come out of my body I feel

like it's my responsibility to take care of that and that's what I will do (Sofie, Interview #1).

These mothers take the responsibilities that come with their parental role seriously; they deal with their stresses and look to the future with their children's best interests in mind. They are very protective and vigilant and, as they make decisions about their lives, they put their children's needs first. These young mothers made comments like: "I would do anything short of killing somebody or stealing to give him what he needs" (Patricia, Interview #1); "I would jump in front of a bullet for my children." (Wendy, Interview #2); "it doesn't matter as long as I have him" (Elaine, Interview #1); "I wouldn't change that [having children] for the world cuz they are my world" (Rebecca, Interview #1); "Whatever is needed, whatever has to be done, you know, I can do it for him." (Lauren, Interview #1); and "I was protective before but now I'm fierce and I know that has to do with the responsibility of protecting my child" (Patricia, Interview #1).

Some of the mothers talked about how their children are the forces behind them. It is their concern for their children that keeps them going and gives them a reason to continue when they are tired of their lives or their responsibilities and they just want to escape from these stresses. Some of the comments include:

I try to do the best I can with it [her house] and there's some days where I just, I don't even care. I don't want to get up; I don't want to touch anything because it's just, it's kind of like what's the point? It's just going to get messed right back up. Then I get to looking around and I get to seeing things and I'm like, well I can't let my kids go around in filth. Which, my house will never get filthy, it's just everyday dirt and then so I'll get up and I'll clean it up. (Tammy, Interview #1)

Whenever you're off work you know and sometimes I just feel like going into a room and locking myself in there and never come out but I don't because if I give up on my kids there wouldn't be anybody to take care of them, you know? I mean, I know my mom would take care of them but it's not my mom's responsibility to take care of my kids and... I'm not going to leave my kids with my mom cuz I've thought plenty of times, you know, my kids would be better off without me but I wouldn't want to grow up without a mom. (Elizabeth, Interview #1).

I'm always afraid I'm gonna start getting depressed and I'm gong to start, you know [getting very depressed], and I don't have time. Yeah, I do my crying and then, you know, I get back to doing what I got to do, you know, so. And inside I feel horrible, very depressed, very, you know, but outside I can't show that because I've got to think of my daughter and the baby and, you know, making sure the house is clean. (Rebecca, Interview #2)

Life is not easy for any of these women but they all manage to do what they expect of themselves. They care for their children in the way they believe is right and that they can afford. They are able to navigate life on most days because their children need them. As Lauren said, "Whatever is needed, whatever has to be done, you know, I can do if for him" (Lauren, Interview #1).

When writing field notes after each visit I made notations regarding the mother's attentiveness to their child(ren) during our interviews. There were a few interviews during which the baby was not present, napping, or being cared for by another member of the family in the home. Additionally, there were toddlers or pre-school age children

present in some homes. During all of the interviews I found these mothers to be attentive to their children and to be ever aware of where the children were, what they were doing, and what they needed.

### *Hopes and Dreams*

While it is true that many of these women expressed the thought that their lives were never going to get better; it is also true that they all had some hopes or dreams for the future. Hope is defined in the New Oxford American Dictionary (Jewell & Abate, 2001, p. 819) as “a feeling of expected desire for a certain thing to happen” and dream is defined as “a cherished aspiration, ambition, or ideal” (p. 518). All of these women had some hopes and dreams for the future and, in spite of general feelings of hopelessness, they never lost site of all of their hopes dreams. Many of these hopes for the future, dreams, or goals were on a small scale and some women were less sure than others of seeing their hopes realized. Elizabeth said, “I always expect the worse but hope for the best; that way I am not disappointed.” The important thing is that each of these women had at least one positive hope or vision for the future and each gave some consideration to their child(ren) in these dreams.

Sofie said:

I would like to get me a house, you know, all that kind of stuff like a family has. Nice cozy house, just be a family, you know. But of course I have to live with people because I can't afford to be on my own because I have four kids and they're very expensive (Sofie, Interview #1).

Some spark of that hope remains alive and she went on to say, “Yeah, some day but I'm not going to hurry and rush it” (Sofie, Interview #1).



Elaine's dreams at this point are to be able to drive. She recently got her driver's license and said she has a vehicle to drive after everything is in order. She points out of the window to a truck parked in her yard and said "That's my truck; I've just gotta put new tires on it and pay my taxes and get it inspected" (Elaine, Interview #1).

Talking about having to parent alone and the future Lauren said:

I just figured now that it's actually hit me that he's [the father of her baby] not gonna have something to do with him then that's fine and it's gonna be fine because I'll make it fine, I'll make sure that he's taken care of and he gets everything he needs and as much love as he can possibly handle (Lauren, Interview #1).

Later in the interview she said: "Hopefully, maybe a few years down the road, I'll find somebody that'll love me and him and at least play a role cuz there's no telling if his real dad's gonna come along."

One of Rebecca's big plans is to get her license to drive. It is being realized slowly but she is working toward it and believes it will happen and will give her a sense of independence that she does not currently have and will let her escape some of her stressful moments. She said:

That independence, you know, I don't have that yet. I don't have my own, you know, independence, where I can say, "OK, kids lets go somewhere. I'm tired of here and let's go." I can't deal with it. And I know after I'm able to do that I think it's going to help a lot (Rebecca, Interview #2).

Rebecca also talked about her plans to get into a home of her own and the contacts and the plans she is making for this to happen. She said she had some

information about a group that will help “if they can get land donated then they help build you a house. I already have property; I’m going to talk to someone again about it and see, you know, what more I have to do for it” (Rebecca, Interview 2).

Tammy is looking forward to her husband getting back to his old job. She expects things to feel a little better at that point because they will be in a better position financially and not “fight about everything.” She also said:

It’s a lot easier cuz I feel like I’ve got a little bit more freedom like if I decide I just want to go out and get something to eat tonight instead of cooking something I can. If I’m like well I don’t feel like washing the dishes today I don’t have to listen to him gripe about it which normally I try to keep my dishes done up but you know you get in those moods where you just don’t want to do nothing, whenever you just don’t feel good or whatever. You just kind of lounge around the house and so... it just makes it a lot easier whenever he’s doing his thing because he’s a lot happier out there on the road anyway cuz that’s something he enjoys doing because he likes to travel plus he’s making money doing it (Tammy, Interview #1).

Lauren said, “I want to be alone and be independent and not be living off anybody, you know. I just know I’ll make it happen” (Lauren, Interview #1).

Wendy has big plans for the future. She was quiet as she began to talk about her hope for the future and as she continued she began to talk with more animation and enthusiasm than previously. She said:

We want to move when he’s off probation we’re um going. I don’t care where we go. I don’t care if I live in my car. I have to plan to go somewhere not knowing

what I'm gonna do. My whole life's been about, I plan. If I'm just going to the doctor sometimes I have to plan on when I'm gonna leave....I don't want to do that.... I just want to be able to go somewhere and do something; get a babysitter and me and my husband go to Vegas or something. That will be nice but I can't fly, that just freaks me out....Yeah, it would be so-o-o nice (Wendy, Interview #2).

Gretchen said she thinks things will feel better for her when her children are a little older. She said:

I just think it I will be, you know, a lot better and easier when they're older; whenever they don't have to have me over them all the time. When they're big enough that I can say "come on guys let's go into town, go get in your car seats." You know, go out and get yourself in (Gretchen, Interview #2).

During interview #2 Gretchen said that her husband was incarcerated again and that he would be released soon. She said she had hope that it would be a little better financially now because he said he wanted to "stop doing everything [alcohol and drugs] and, you know, go to AA and different things like that so, and counseling and stuff and I don't know, we'll have to wait and see I guess" (Gretchen, Interview #2).

For Martha, right now she looks forward to her son growing up and said, with a chuckle, "there's always a light [at the end of the tunnel]; he gets big, he gets a big job, and supports you." There is a community college about 50 miles from her home and she hopes to be able to start taking courses there as soon as her medical issues are resolved. She said she hopes one day to be a paralegal, teacher, or maybe even an attorney. She

said she has “thought about being a lawyer and finding dead beat dads” (Martha, Interview #1).

When Elizabeth talked about her life and her future, she said, “I’m scared to death to be happy.... Whenever I did think all positive and was happy all the time nothing but bad stuff happened.” In spite of this feeling she said that she still has hopes of:

Having somebody there, you know? Like, I want to be married one day and have a family and I know people are like, hey, you’ve got a family already, you know, it’s you and your kids. That’s not the same, you know. That’s, I mean my kids are my life. They’re the ones that, that keep me alive and keep me going. But I want somebody there, you know to, to talk to and, you know, to share things with, you know. But your kids won’t really understand because they’re just kids and they won’t understand until they go through the same thing ( Elizabeth, Interview # 1).

One of Patricia’s dreams is to become a nurse. She said: “I still want to finish school.... I want to be a trauma nurse” (Interview #1).

All of these women maintained some sense of hope and had some dream for the future. Some of these dreams were small like Gretchen’s vision of a time when her children would be a little more independent and not need her every moment of the day; some were on a much grander scale like Patricia’s dream to become a trauma nurse. What is important is that none of the women in this study were without at least a glimmer of hope that the future would bring some sense of relief from what they were currently experiencing.

## CHAPTER V: DISCUSSION

### Overview

This study revealed some important insights concerning postpartum depression symptoms in women living in rural areas of the Missouri Ozarks. The experience of living with postpartum depression symptoms is one that is shared by mothers all over the world but the meaning it has for the women who live it is shaped by the culture in which they live (Horowitz et al., 2001). For this reason it is important to discover the meaning of living with postpartum depression symptoms for women living in rural areas of the United States.

During textual analysis seven themes emerged; five of the themes were determined to be essential and two are incidental (van Manen, 1990). The themes of Overwhelmed and Stressed, Loss, Financial Concerns, Abandoned and Alone, and Fiercely Responsible are essential. The themes Stuck Here and Hopes and Dreams were judged to be incidental because, while they were themes that were found in all of the interviews, they did not manifest themselves as essential to the phenomenon. The experience of postpartum depression symptoms would exist without the themes of Stuck Here and of Hopes and Dreams. These are, however, themes that were common to all of the mothers and their presence serves to amplify some of the feelings, meanings, and realities of their experiences, especially those related to stress and finances. The feelings of being stressed, overwhelmed, tired, tearful, anxious, irritable, lonely, angry, frustrated, as well as a sense of loss and of not receiving help or support in the ways they believed to be helpful are feelings that have been found across qualitative studies of postpartum

depression (Beck, 1992; Beck, 1993; Chen, Levy, Chung, & Lee, 2002; Horowitz et al., 2001; Ugarriza, 2001). The meanings or interpretations of these feelings, however, were found to be somewhat different in this population. The theme of financial concern was not found in other qualitative studies but it was not surprising that it came to light in this study considering the demographics of the population. The emergence of the themes Fiercely Responsible and Hopes and Dreams were interesting and unexpected findings.

#### The Meaning of Living with Postpartum Depression Symptoms

The women in this study were overwhelmed by the difficulties and responsibilities in their lives as well as by the financial difficulties that they were experiencing. There was little help available for these women and they did not see the situation changing or improving in the foreseeable future. What these mothers did see, which seems to differ from what was reported in other studies, was that they had both the strength and the ability to make it through the experience and to provide for their children's needs. Some had a stronger sense of this than others but all believed they could succeed. The one participant who questioned her ability to provide adequately for her baby said she had been emotionally and psychologically abused by her baby's father and had also experienced a potentially life threatening postpartum complication two weeks after delivery. These events may have placed her in a position of greater vulnerability than the other participants.

All of the women in this study were experiencing significant financial difficulties. Many of these difficulties related to the scarcity of jobs in the area as well as to low wages and the absence of benefits or opportunities for advancement. These women and their families felt isolated from opportunities that might make their lives and the lives of

their children better. Some of the women blamed at least a portion of their difficulties on the debt their husbands brought to the relationship and on their husband's poor work effort. Of the fathers who were employed, three brought a significant amount of debt to the relationship and three of them left their jobs and had to return to jobs that paid less. Of the women who were working outside the home and were the sole or principal source of income for themselves and their children, all were able to return to their jobs and care for their children after their babies were born. One of these, a single mother of four, was unable to continue working after several months. One of the mothers made an interesting comment about her view of this situation. She said: "We're now the wife, the mother, the housekeeper, the provider.... We're doing it to survive, to make a life for our kids" (Patricia, Interview #2).

There was a sense of loss that was universally experienced by these women. For some of the women, it was a loss of the person she was before becoming a mother; for others, it was no longer being noticed or appreciated for who she was; for some it was the loss of a relationship or the loss of friends she previously had; and for some it was the loss of the freedom of youth. Whatever the source, all of these women experienced losses that were related to their becoming mothers.

Beyond the feelings associated with these losses was the feeling of abandonment that these women experienced. One of the mothers said that it was knowing that she would be left alone to raise her children that "depressed" her the most. It was made more painful for some women because they also witnessed the abandonment of their child by a parent. This was, for some, the greatest source of pain, anger, and frustration. One of the women admitted that she had expected to be ignored but she had not expected the father

of her child to abandon their child as well. Even among those women who were not physically abandoned there was a sense that they had, in some way, been abandoned by the father of their children. Mothers who did not experience the support of the father of their child or did not witness him engaging in some of the childcare routines felt that they had been abandoned and left alone to parent.

The feeling of being stuck that was experienced by virtue of their geographic location added a layer of complexity to women's already difficult lives. Distance increased the burden of time, effort, and finances involved in routine events such as traveling to and from work, physician's visits, or shopping. These mothers expressed their isolation as a feeling of being "stuck" in their homes, their communities, and in an area with few opportunities for employment or advancement. There were no mothers in the study who saw Stuck Here as a cause for any of their feelings but all saw it as a confounding factor. While feeling stuck where they were may not be a causative or precipitating factor, the absence of feeling stuck might have a moderating effect on postpartum depression symptoms.

What is most striking is the fierce sense of responsibility that these women felt toward their children. In the lives of these mothers, their children always came first. Furthermore, they never placed blame on their children for the way they were feeling or the difficulties they were having. When speaking of their tearfulness, irritability, anger, or frustration, these mothers often said that it was not the baby's fault they were feeling that way and they would attempt to shield their children from their moods. When the mothers spoke of finances, the children's needs always surfaced as a priority. None of these



women ever mentioned ambivalent feelings toward their children nor did they ever discuss thoughts of harming them.

All of the women in this study had some hopes, dreams, or plans for the future. For some, these were small but none of the women lost sight of all of her hopes and dreams. When these women discussed their hopes and plans for the future they always included consideration of their children.

### Revisiting the Literature

Since 1992 there have been several qualitative studies that have shed light on how women in this country, as well as in several countries around the world, describe their experiences of postpartum depression or of postpartum depression symptoms (Beck, 1992; Beck, 1993; Chen, Levy, Chung, & Lee, 2002; Horowitz et al., 2001; Ugarriza, 2002). All of these studies examined women living in urban areas in the United States and around the world. This study, which focused on rural women, revealed a new understanding of postpartum depression symptoms as they are experienced by women living in the rural Missouri Ozarks. The findings included similarities as well as dissimilarities when compared to experiences described in qualitative studies of postpartum depression (Beck, 1992; Beck, 1993; Chen, Levy, Chung, & Lee, 2002; Horowitz et al., 2001; Ugarriza, 2002).

Ambivalent feelings or thoughts of harming the baby that were found in some of the qualitative studies of postpartum depression (Beck, 1992; Chen, Levy, Chung, & Lee, 2002; Ugarriza, 2002) were not found in any of the women in this study nor did any of the women see their baby as the cause of problems between themselves and their husbands or boyfriends. Two of the mothers did recall being told by others that the birth

of a child would bring them closer to their partners and both said that they had not found that to be true. One of the women in this study saw the pregnancy and birth of her children as the cause of drastic changes in her relationship with the father of her children but blame was placed on her partner and not on her children. This mother questioned why the experience was so different for men than it was for women. She said that for men it was a feeling of being “trapped” forever and for a woman it was the “best thing that could ever happen.” Another mother in this study talked about her earlier feelings of not wanting to care for her baby or even to be in the same room with him but said that those feelings had gradually changed and were not present by the time of our first interview. At the time of the second interview those feelings had been replaced by significantly more positive feelings. Rather than the feelings of guilt because they could not give their infants the love they believed they needed (Beck, 1992) all of the women who participated in this study expressed feelings of love for their infants and demonstrated positive emotion when attending to or talking about their babies. An unexpected finding in this study was the fierce sense of responsibility these mothers felt toward their babies. All of the mothers expressed an unwavering sense of responsibility and determination to do the best they could for their children.

Beck (1992; 1993) found that the women in her studies saw their lives as empty and devoid of all of their previous interests and goals. Some of the women in the present study admitted that activities they had once enjoyed no longer gave them pleasure and all of them saw their lives as significantly changed. In spite of this, all of the mothers were able to articulate their dreams for the future. These hopes and dreams included the themes of education, homes, families, and relationships.

Some of the mothers in this study mentioned being insecure with their ability to care for their infant and one mother was still feeling insecure about her inability to successfully comfort her crying infant. None of the other women in the present study discussed major insecurities or the need to be mothered beyond the initial few days or weeks immediately following the birth of their infants that Beck (1992) found. All of the mothers in this study did, however, have a need for some kind of ongoing help and support. The support discussed by the mothers in this study was not related to insecurities but to being overwhelmed with all of the tasks related to mothering and to household chores. They all had a sense that they could do whatever was needed but felt that, at times, it was too much for one person to accomplish.

Some sense of loneliness was expressed by women in all of the studies. Unlike the loneliness due to self isolation (Beck, 1992), the women in this study attributed their loneliness to factors such as physical distance from friends and relatives, dissolution of a relationship, and inattentiveness and lack of support from their husbands or partners. This lack of attentiveness and support from husbands and partners was also identified in two other qualitative studies (Chen, Levy, Chung, & Lee, 2002; Ugarriza, 2002).

In contrast to Beck's (1992) findings, none of the women in this study were actively contemplating harming themselves and only two admitted to even having contemplated this in the past. Like the mothers in other studies (Chen, Levy, Chung, & Lee, 2002; Ugarriza, 2002) the women in this study did see their lives as changed and some admitted, when questioned, that they feared their lives would never be the same again. Most of the mothers in this present study were troubled but were not hopeless about the prospect of their lives never being normal again. Some of the women in this

study referred to the “new normal” or the “different normal” that was their current life and all had some glimmer of hope or some dream for the future to which they continued to cling. This was similar to the women in the study by Chen, Levy, Chung, and Lee (2002) who began to find solutions or “means of escape” from their feelings of being “trapped in the situation.” The women in this study, however, did not include some of the more negative solutions that appeared in the Chen, Levy, Chung, and Lee (2002) study.

Loss was a universal theme that emerged in all of the qualitative studies of postpartum depression that were reviewed (Beck, 1992; Beck, 1993; Chen, Levy, Chung, & Lee, 2002; Horowitz et al., 2001; Ugarriza, 2002). What was lost or how the loss is perceived differed among groups but all of the studies found that the birth of a child was accompanied by a sense of loss. The loss of time and energy, the loss of self and the activities in which one previously engaged, and the loss of relationships were all present in some form. For new mothers it was a challenge to find the time or energy to eat or shower. These mothers were no longer able to go out and enjoy the company of their friends and some actually lost, at least temporarily, their old friends because they were no longer able to spend time with them. This was the situation in which one mother found herself. She told of the birthday parties she planned for herself and to which no one came because she had not able to attend the parties of others.

Finally, the financial concerns expressed by these women were not found in any of the other qualitative studies of postpartum depression or postpartum depression symptoms. It is not a surprise, given the economic state of the area in which these women live, that financial concerns played a pivotal role in their postpartum experience. Both the financial concerns and the experience of feeling stuck, for these women, were shaped by

the cultural context which is significantly different as compared to those in the other qualitative studies that included predominately middle income, educated, married women.

### Fusion of Horizons

Each of us sees our world from our own horizon or vantage point; we each see it from atop our own mountain. It is when we fuse our horizon with the horizons of others that we come to see and to understand experiences in a new and different way (Gadamer, 1960/1989). It was through the dialogue that occurred in interviews with the women in this study and the dialogue that occurred in the reading and re-reading of other qualitative studies of postpartum depression or postpartum depression symptoms that the experience of postpartum depression and the experience of women living with at least some of the symptoms of postpartum depression was revealed. It was revealed in a way that is somewhat different from the ways in which it was formerly seen. Previously it was seen from the perspective of urban women and this study provides the viewpoint of rural women. Through the fusion of these two vantage points or horizons we are able to continue to broaden our knowledge of the experience and to gain an understanding of what these women are experiencing. This new understanding will, hopefully, provide new insights for clinicians and assist researchers in the design and testing of interventions to help prevent or lessen the impact of postpartum depression and postpartum depression symptoms on women and their families.

### Revisiting the Process

After the first few interviews I began to end the initial interviews by asking the participants to sum up, in a couple of words or sentences, their experience as a new

mother. A conversation with Patricia Munhall (personal communication, June 27, 2004) guided me to ask the initial question: "What has it been like for you since your baby was born?" This allowed the women to relate their postpartum experiences in the way that was meaningful to them rather than in a manner that was meaningful to me or that was led by my pre-understandings or prejudices. As a result of this, as well as the conversation or visit format, the interviews were often lengthy and, at times, they seemed to stray from the women's descriptions of their experiences of postpartum depression symptoms. The request that the women in the study provide a summation of their experience as the interview was drawing to a close was intended to provide them with the opportunity to refocus on the purpose of the dialogue. Each of them summed it up in basically the same manner by saying that it had been a very difficult experience. In retrospect, most of what was said by these women was not off topic; it was their way of letting me know that the postpartum experience had been difficult for a variety of reasons. A life that was already difficult had become more so by the addition of a child. All of the mothers seemed to genuinely love and treasure their infants but all groaned under the weight of another life for which they were responsible. Some had planned to embark on the journey of parenthood, others embraced the arrival of their new baby only after tears, grief, denial, anger, and disbelief, and at least one mother found acceptance only after coming to the realization that there was no one else who was going to care for her infant so she would have to do it. All of these mothers came to see their infants as a treasure to be cared for and protected at all costs.

### Rural Reflections

Working among and doing research with women in rural areas has its own set of challenges. The women in this study did not consistently call to reschedule an interview nor were they always home at the mutually agreed upon time. It took three months to finally have the opportunity for a first interview with one participant. Because I was familiar with the culture I avoided the temptation to take this difficulty as a sign of avoidance. Women who spend many hours each day with no companionship and no transportation are often eager to take advantage of an opportunity to have a visitor or to join a friend or family member on a trip to a neighboring community to shop, get groceries, or just enjoy an outing and companionship. These women also have little control over the time they leave or the time they return to their homes and they may or may not have a means of calling to reschedule a visit if they are not going to be at home. Having lived and worked in this community for seven years I was very familiar with these behaviors and, as a result, I continued to reschedule until we finally had the opportunity to complete our first interview. There is a need for flexibility when working with this population and to remember that, for the most part, these women do not live the scheduled and structured lives that those in more urban areas often live. It is important for the researcher to be respectful of the life styles of the study participants and to make the necessary accommodations rather than to expect the participants to do so. The way these women have come to live and experience life is different when compared to the way many of us live our lives. The way lives are lived in many rural areas is neither better nor worse than the way they are lived in many more urban areas; it is just a different way.

### The Women's Voices

All of the women in this study wanted their voices heard. It was important to them to tell their story and to know that it had been heard. Three of the women in the study included suggestions that they believed would be helpful for other women. One of the women said that she did not believe there was an adequate dissemination of information regarding postpartum depression. She thought all childbearing women and their families should be told that it could occur and the symptoms to be alert to. She was especially emphatic about the point that families should be informed because they might often be the ones to see the signs first and to take appropriate action. A second woman said she believed that the high schools should require courses in childcare and the demands it places on new parents. She added that she believed all of the students, male and female, should be required to take the course. In addition she said that she thought all of the male students should be required to take home the "Baby Think It Over Simulator" to give them an idea of what it was like to have to deal with a crying and hungry baby on a regular basis. The third woman had advice for expectant parents. She suggested that they spend time together during the last weeks before delivery and do something special like go out to dinner, a movie, or even a quiet walk. She said this helped both her and her husband through those early days when couples often feel ignored and neglected by their spouses or partners.

Seven of the ten women who participated in this study had the opportunity to review the findings of this study and the interpretation of the meaning of living with postpartum depression symptoms for these women. All seven agreed with the findings and interpretation. Rebecca said: "Reading it was like a walk in my shoes; it summed it



up.” Elizabeth sat in silence after reading it and, when questioned, she quietly said: “that’s it.” None of the women offered any suggestions, clarification, additions, or deletions and all said what they read sounded like what they had experienced.

### Clinical Implications

The length of time required to complete this process was significantly longer than expected. One of the greatest sources of delay was related to identifying new mothers who might meet the eligibility criteria. Whether this was reluctance on the part of nurses and other health care providers to label a new mother with symptoms of postpartum depression or a lack of sufficient information regarding the signs and symptoms of postpartum depression is unknown. Whatever the reason, it gives us cause to examine and clarify the role of nurses in identifying new mothers who are experiencing signs and symptoms of postpartum depression. Nurses and other health care providers need to have the knowledge as well as the tools necessary to identify women at risk for developing postpartum depression symptoms and referral resources that can be utilized when these women are identified.

### Directions for Further Research

Previous qualitative studies of postpartum depression in the United States as well as the study of postpartum depression symptoms in women in several different countries (Beck, 1992; Horowitz et al., 2001; Ugarriza, 2002) included only women from urban areas. This is the first study found that targeted women in the rural areas of the United States. The characteristics of the rural communities in the United States and their residents vary significantly from one geographic area to another making it important to extend this study to include a variety of rural areas. It is important to know more about

the experience of postpartum depression symptoms in women living in these areas. The more clearly we, as researchers, are able to sketch a picture of postpartum depression symptoms and postpartum depression the better able we and other clinicians will be to design and test interventions to help prevent and treat postpartum depression.

Another area for future research was highlighted by Horowitz et al. (2001) who found that the women in their study from the Boston site began to experience a resolution of symptoms once they were able to connect with other women who shared their experiences. In the current study there were several women who expressed a need to confide in other women whom they thought would be able understand their situation. One of the mothers in this study expressed this sentiment, saying: “I’m at a point where you have to have a female to talk to, to have complete understanding [of the postpartum experience], a female who’s had children, especially, [who has] been through it.” These findings indicate that the design and testing of an intervention that affords postpartum women the opportunity to interact with other postpartum women has the promise of providing some relief but the challenges remain great in rural areas.

#### Cautions

It is imperative that the reader keep in mind that this was not a study of postpartum depression but, rather, it was a study that examined the experiences of rural women who were living with some of the symptoms that are commonly found in women with postpartum depression. These women were not screened using questionnaires nor were they diagnosed by clinical examination. Whether these women would have met the DSM-IV-TR criteria for a clinical depression is not know. What is known is that there are many women who do not meet the diagnostic criteria for postpartum depression but who

are exhibiting some of the symptoms that are troubling and are in need of intervention and support. The goal of this study is to provide clinicians with a new view of how postpartum depression symptoms are experienced by women living in the rural Missouri Ozarks; a population often not understood and just as often overlooked.

### Epilogue

Sadly, of the seven women who participated in the third round of interviews, only two were feeling considerably better. Rebecca is planning a wedding and has renewed hopes of being able to move into a home of her own sometime in the not too distant future. Patricia said she is feeling somewhat better at the present. Elizabeth continues with counseling and medication but said she is feeling worse than she had been at the time of our second interview. Martha said she is not feeling any better than she was during our earlier interviews and now has serious concerns regarding the joint custody arrangements and the care that her son is receiving while he is with his father. Tammy is not feeling better and indicated that some things in her life were feeling worse for her now than they had been during our initial interviews. She has had to transfer her oldest child to a state school because of the inability of her local school district to provide needed services and her husband has not returned to his previous job so their financial concerns have not abated and they are having increasing difficulties with their relationship. Wendy and Gretchen indicated that they were feeling pretty much the same. For Wendy and Elizabeth the lack of access to medical care is currently a serious issue. Neither can afford private health insurance and they do not currently qualify for either MC+ or Medicaid. Elizabeth said she feels like the state almost forces women into repeated pregnancies as a way of maintaining their medical benefits. Her medications are

no longer effective in managing her depression and she is not able to see a psychiatrist for help with the regulation of her medications because she has no health insurance. Health insurance is a major problem in this area for those who are employed. The local wages are not sufficient to make health insurance premiums affordable and those who work, for the most part, are not eligible for Medicaid or MC+.

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### Eligibility Criteria Checklist

1. At least 18 years of age, \_\_\_\_\_
2. Receiving Missouri MC+ or Medicaid, \_\_\_\_\_
3. Delivered healthy term infant (at least 37 weeks gestation) within the past one to twelve months, \_\_\_\_\_
4. Live in Carter, Reynolds, Shannon, or Wayne counties in Missouri, \_\_\_\_\_
5. No history of a psychotic or major depression outside the perinatal period, \_\_\_\_\_
6. Admits to experiencing at least two of the following since the birth of their baby:
  - Sleep disturbances \_\_\_\_\_
    - Trouble going to sleep or staying asleep even when the baby is sleeping
    - Sleeping or wanting to sleep all of the time
  - Eating disturbances \_\_\_\_\_
    - Decreased or loss of appetite
    - Overeating or eating even when not hungry
  - Feeling anxious, panicky, insecure or overwhelmed (even over little things related to the baby or not related to anything in particular) \_\_\_\_\_
    - Feeling overwhelmed or inadequate for the task of mothering
    - Overly worried or concerned about the baby
    - Anxiety that gets in the way of doing things such as caring for the baby or self
    - Feeling like you just have to keep moving
    - Feeling alone or deserted
    - Feeling inadequate for the task of mothering
  - Emotional lability \_\_\_\_\_
    - Crying more than usual or crying over “little things”
    - Feeling like you are on an emotional roller coaster
    - Feeling very irritable
    - Feeling angry and ready to explode
    - Feeling sad or miserable
    - Absence of joy or inability to see the funny side of things anymore
    - Feeling sad and alone
    - Feel like you are going crazy or losing your mind
  - Loss of “normal” \_\_\_\_\_
    - Feeling like you don’t even know who you are anymore
    - Feeling like things are just never going to get better or that you are never going to be yourself again.
    - Feeling like your life is never going to be OK again
  - Irrational thoughts \_\_\_\_\_
  - Difficulty staying focused or concentrating on even simple tasks or making even simple decisions \_\_\_\_\_
  - Guilt about the way you are feeling \_\_\_\_\_
    - Feel like a failure as a mother or like you are not the mother you wanted to be.
    - Do not want anyone to know how you feel about the baby or about your self as a mother.
  - Alterations in thinking that may include strange, obsessive or irrational thoughts or thoughts of harming self or infant? \_\_\_\_\_
    - Feel like you would be better off dead
    - Wish you would wake up and find that this has all been a dream
    - Feel like the baby would be better off without you
    - Feel like you would just like to disappear from this world
    - Have thoughts of hurting self or baby

## Demographic Data Sheet

1. What is your age? \_\_\_\_\_ DOB? \_\_\_\_\_
2. How many times have you been pregnant? \_\_\_\_\_
3. How many children are living with you now? \_\_\_\_\_
4. How many adults live in your home? \_\_\_\_\_
5. Is there someone you can count on to help you with the job of parenting your child or children?
  - a. \_\_\_\_\_ never
  - b. \_\_\_\_\_ almost never
  - c. \_\_\_\_\_ some of the time
  - d. \_\_\_\_\_ most of the time
  - e. \_\_\_\_\_ almost always
6. What is your marital status
  - a. \_\_\_\_\_ single and see the father of your baby less often than once a month
  - b. \_\_\_\_\_ single and see the father of your baby 2 or 3 times a month
  - c. \_\_\_\_\_ single and see the father of you baby at least once a week
  - d. \_\_\_\_\_ married or living together
  - e. \_\_\_\_\_ separated
  - f. \_\_\_\_\_ divorced
  - g. \_\_\_\_\_ widowed
7. What is your employment status?
  - a. \_\_\_\_\_ employed
  - b. \_\_\_\_\_ unemployed
  - c. \_\_\_\_\_ on maternity or medical leave
  - d. \_\_\_\_\_ actively looking for employment
8. What is your source of income? \_\_\_\_\_
9. How is your health care paid for?
  - a. \_\_\_\_\_ MC+
  - b. \_\_\_\_\_ Medicaid
  - c. \_\_\_\_\_ Other (please specify) \_\_\_\_\_
10. How long have you lived in this county or a neighboring county? \_\_\_\_\_



## College of Nursing

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### **Informed Consent for Participation in Research Activities**

Missouri Ozark Women's Experiences of Living with Postpartum Depression Symptoms

Participant \_\_\_\_\_ Approval Number 050808W

Principal Investigator Nathalie Williams PI's Phone Number \_\_\_\_\_

#### **Why am I being asked to participate?**

You are invited to participate in a research study about what life is like for new mothers who live in Carter, Reynolds, Shannon, south Iron, or Wayne counties in Missouri and have some of the same symptoms that women with postpartum depression have. This study is being conducted by Nathalie Williams from the College of Nursing at the University of Missouri-St. Louis. You have been asked to participate in the research study because you said that you are experiencing two or more of symptoms that are experienced by women with postpartum depression. We ask that you read this form and ask any questions you may have before agreeing to be in the research. Your participation in this research is voluntary. Your decision to participate or not participate will not affect your current or future relations with the University or any county or community service providers from whom you are currently receiving services. If you decide to participate, you are free to withdraw at any time without affecting that relationship.

#### **What is the purpose of this research?**

The purpose of this research is to learn more about what everyday life is like for you and other new mothers who live in this area of the Missouri Ozarks and have some of the symptoms of postpartum depression. A better understanding of your experiences can help me and other nurses to have a better understanding of what everyday life is like for you and what we might be able to do to help to prevent some of these symptoms in the future.

#### **What procedures are involved?**

If you agree to participate in this research, you can expect:

1. to fill out a short one page questionnaire about yourself;
2. that I will come to your home three times to visit and talk with you about your experiences of being a new mother.

3. that each time I come to your home I will tape record our visits. (If you feel uncomfortable about this we can talk about it first and practice with the tape recorder if you like);
4. that NO one else in your family or in this community will be allowed to listen to these tape recordings (You may listen to these recordings at the end of our visit if you like);
5. these tape recordings to be typed word-for-word by either myself or someone in a different part of the state; and;
6. that during our second and third visit you will be able to read what was typed and be sure that it is what you said as well as what you meant to say and that I correctly understood you at our last visit;
7. that what we talk about in these visits and how long they last will be up to you;
8. the average visit to last about an hour and the time between visits to be anywhere from one to four weeks;
9. that we will visit and talk about 3 times during this study and that this may take up to 3 months;
10. these visits will take place in your home or in another place that we both agree on; and
11. there will be approximately 6 to 12 women in this area who will be involved in this research study at the University of Missouri-St. Louis.

### **What are the potential risks and discomforts?**

There are certain risks and discomforts that may be associated with this research. These risks are the possible uncomfortable feelings that might occur when you talk about some of your experiences or that might occur if someone in your home overhears you talking about something you do not want them to hear. If either of these things happens the interview can be stopped and you are free to choose another place and time to meet or you can decide not to continue in the research if you are uncomfortable.

### **Are there benefits to taking part in the research?**

The benefits to you of participating in the research include:

1. giving you a way to talk about what everyday life is like for you as a woman and a new mother,
2. helping me and other nurses learn more about what life is like for you and other women in these counties who have some of the symptoms of postpartum depression so that we might have a better idea of how to help other women with these symptoms in the future,
3. referral to your physician, the family counseling center, or a local counselor for diagnoses and treatment of your symptoms if you believe that your symptoms are troubling and you would like to receive their help,
4. a follow-up call (if a referral was made) to be certain that you have been able to get an appointment with your physician or counselor.

### **What about privacy and confidentiality?**

The only people who will know that you are participating in this study are the few people at the University of Missouri in St. Louis who will be helping me with this project and the person who does not live in this part of the state and who will help me with typing. No information about you or about what we talk about in our visits will be disclosed or given to others without your written permission, except:



- if necessary to protect your rights or welfare (for example, when the University of Missouri-St Louis Institutional Review Board monitors the research or consent process);
- if you tell me that you are presently thinking about harming yourself, your child(ren), or anyone else, I will refer you back to your current health care provider and follow-up within 24 hours to be sure that you were able to make arrangements to be seen by your provider; or
- if required by law such as in the case of child abuse or neglect (as a nurse, I am mandated by law to report chase of child abuse or neglect).

When the results of this research are published or discussed in conferences, no information will be included that would reveal your identity. If audiotape recordings of you will be used for educational purposes, your identity will be protected or disguised. Any information that is obtained in connection with this study, and that can be identified with you, will remain confidential and will be disclosed only with your permission or as required by law.

The tape recordings of what we talk about during our visits will be transcribed or typed by the researcher or by a transcriptionist or typist in another part of the state. There typed transcripts will not have your name on them; they will only have an identification code. You have the right to listen to any of the tapes of our visits and to read the typed transcripts of the tapes.

Personal identification sheets containing your name, identification code, telephone number or contact number, mailing address, and directions to your home will be kept in a separate locked file to which only I will have the key. The personal data sheets, tapes, and the typed transcripts will be identified with a code number and NOT names and will also be kept in a locked file cabinet to which only I have the key. The tapes, personal data sheets, and transcripts will not be used for any other purpose without receiving your written consent for another specific use of this information.

The research team (those from the University of Missouri who will be helping me with this study will) may use and share your information only with one another only for the purposes of helping me with this study and only until the research project is complete. After the study is complete I will destroy the tape recordings and remove the identifiers from your information, making it impossible to link you to the study.

### **What are the costs for participating in this research?**

There are no costs for which you will be responsible. There will be no cost to you for your participation in this research project.

### **Will I be paid for my participation in this research?**

You will not be paid for your participation in the study but you will receive a small gift at the end of the study to express our appreciation of your participation.

### **Can I withdraw or be removed from the study?**

You can choose whether to be in this study. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You also may refuse to answer any questions you do not want to answer and still remain in the study. The investigator may withdraw

