

Postpartum Depression and the Meaning of Motherhood:
Exploring the Role of Contrast and Expectations

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By

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ABSTRACT

Postpartum depression affects between 10 - 15% of all mothers within the first year after giving birth (Dietz, 2007; Epperson, 1999). Studies that have focused on women's experiences of postpartum depression have found similar in experience of contrast between women's expectations of motherhood, and their actual experiences (Beck, 2002; Knudson-Martin & Silverstein, 2009; Mauthner, 1999). Using a phenomenological approach, this study sought to explore women's experiences of contrast, understand how this experience contributed to their social construction of what motherhood meant, and ask if and how women might change the messages that they receive regarding being a mother.

Seven women were recruited from a postpartum depression support group and interviewed in a focus-group setting. Respondents noted that they experienced a great contrast between their expectations of motherhood and what they actually experienced. These expectations, however, seemed ambiguous and generic. Women reported that they were surprised by the amount of judgment and pressure they felt surrounding being a mother. Participants seemed to challenge their preconceptions about being a mother by focusing on making choices that were best for them and their children and by allowing unhappy feelings to be compatible with their definition of a good mother. Women in the study described wanting to hear messages that were honest and open about the realities of motherhood, both from the media and in their interactions with other women and loved ones. Participants also seemed to feel strongly that more efforts should be made to reach out to new mothers.

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Chapter 1: Introduction

The Problem and its Setting

Postpartum depression affects nearly 10-15% of women within the first year after giving birth (Dietz, 2007; Epperson, 1999). Cases of postpartum depression (PPD) often go undiagnosed, as some symptoms can be difficult to distinguish from the telltale markers of new parenthood such as fatigue and loss of sleep. Postpartum depression is diagnosed using the same criteria for major depressive disorder as outlined in the fourth edition of the American Psychiatric Association's Diagnostic and Statistical Manual (2000), and therefore symptoms of postpartum depression are similar to those typical of major depressive disorder such as insomnia, feelings of worthlessness, and loss of concentration. In PPD, however, most feelings of helplessness and failure are associated with performing the motherhood role (American Psychiatric Association, 2000; Epperson, 1999; Harvard Medical School, 2011). These feelings of failure add to the already stressful responsibilities and adjustments of parenthood.

The impact of postpartum depression on women's lives is not isolated to the Western world. Women across racial and cultural boundaries report experiencing postpartum depression in much the same way, citing isolation, invalidation, and a spiraling depression (Beck, 2002; Gao, Chan, You, & Li, 2009; Knudson-Martin & Silverstein, 2009). In most cultures, postpartum depression carries with it a specific stigma and guilt apart from the regular stigma of mental illness (Knudson-Martin & Silverstein, 2009). Motherhood still defines the social construct of a feminine identity for cultures around the world, and everywhere societies have many ideas and ideals about what a mother should be. Societies are critical of how, and stigmatizing of how well, a woman can perform her duties to her children (Medina & Magnuson, 2009). This social stigma may contribute to delayed detection of PPD and a prevalence of less

than half of women with the disorder seeking treatment (Epperson, 1999; Harvard Medical, School, 2011).

The causes of postpartum depression are unknown, however, known predictive factors can help identify women who may be at a higher risk. Predictive factors for postpartum depression include previous episodes of depression (particularly during the prenatal period) childcare stress, life-stress, and lack of social support (Beck, 1996a). While no factors have been found to have a definitive causal link to PPD, higher levels of social support have been shown to buffer against PPD for women who have previously experienced episodes of depression (Howell, Mora, DiBonaventura, & Leventhal, 2009). Although hormonal fluctuations may help to explain women's predisposition to emotional instability after childbirth it is not a complete explanation (Harvard Medical School, 2011). Recent qualitative studies on the personal experiences of women with PPD have further expanded our understanding of postpartum depression to include ways in which relational processes and societal ideals help to sustain postpartum depression (Beck, 2002; Knudson-Martin & Silverstein, 2009; Mauthner, 1999).

Postpartum depression is mainly studied from a medical model and is rarely examined from a systemic lens. However, researchers that have focused on the experiences of women with PPD have discovered similar systemic processes that seem to span across different ethnic groups and socioeconomic groups. These studies describe processes of isolation, worsening distress, and withdrawal that center around women's distress over new motherhood and the shame they carry for not living up to the ideal social construct of a good mother (Beck, 2002; Kudson-Martin & Silverstein, 2009; Mauthner, 1999). According to the models and concepts proposed in Beck's (2002), Knudson Martin and Silverstein (2009), and Mauthner's (1999) studies, these processes begin with a woman's societal construction of motherhood and an experience after giving birth

that is incongruence with this ideal. When women do not experience significant incongruence in their experience, or are able to connect with others amidst this incongruence, express their negative feelings freely, and be heard through supportive reactions, they tend to feel validated and successful as a mother, therefore not experiencing PPD. Women who interpret incongruent experience as signs of incompetence and failure isolate themselves, leading to postpartum depression. Likewise, if a woman does not immediately interpret incongruence as incompetence, but does not find connection with others, is not able to freely express negative feelings about motherhood, or is invalidated in her expression of these feelings, she may also retreat into isolation. As women remain isolated and invalidated in their negative feelings, they become depressed, which in turn isolates them further from possible support systems, furthering their feelings of inadequacy and deepening the problem.

Better understanding of the systemic and interpersonal nature of PPD could provide better treatment and education regarding postpartum depression (Knudson-Martin & Silverstein, 2009). However, it is becoming clear through qualitative research that postpartum depression is not an individual problem for women, but part of the larger societal issue of the social construction of ideal motherhood. Mauthner (1999) described postpartum depression as a woman's "active struggle" between self and the larger community to silence their feelings of inadequacy brought on during the postpartum period. Better understanding of this struggle and the role societal ideals play in a very personal ordeal can help to promote discussion regarding the reality of motherhood and PPD in a societal context. While hormone changes and certain risk factors such as previous depressive episodes and childcare stress are difficult to modify, public discussion and expectations of good mothering are possible to challenge. Promoting new ways of thinking about motherhood could help modify the messages sent to women about the

social constructions of motherhood and how to deal with the inconsistencies they may face in their experiences.

Significance

PPD is not an equivalent of the so-called “baby blues.” The “maternity blues” or “baby blues” are often experienced as mild depression; unexplained tearfulness, increased sensitivity and mood fluctuations; which peak during the third day following delivery and diminish thereafter. In contrast, symptoms of PPD can begin anytime during the months following delivery and last for months (American Psychiatric Association, 2000; Dietz, et al., 2007; Epperson, 1999; Harvard Medical School, 2011). PPD is distinguishable from the “baby blues” by the intense feelings of despair and isolation that are so distressing that they begin to impair the mother’s functioning (Mauthner, 1999). Beck (2002) describes the progression of PPD as a process of “spiraling downward,” underlining the wide spectrum of disruptive and distressing emotions felt by women: from anxiety to obsessive thinking, cognitive impairment, isolation, guilt, and a pervasive sense of loss.

The negative impact of PPD reaches further than just the affected mother. Studies suggest infants of depressed mothers show signs of delayed development in the absence of early facial recognition and social referencing into the first year. These small, but statistically significant delays in development can affect children even into late childhood (Beck, 1998). Due to the integral role of mother-child interactions in infant development, disturbance in normal mother-infant engagement are particularly important in the studies of depressed mothers and their children. According to Field (2000), during interactions with their infants, depressed mothers are more likely to show high state and trait anxiety ratings. The interactions are also less active, there is less game play, and the mothers present with a predominantly depressed or

anxious looking state (Field, 2000). In studies, mother/infant dyads with depressed mothers are slower to initiate positive affective matching during play and slower to repair mismatched affective states into positive states (Reck, et al., 2011).

Rationale

Knudson-Martin and Silverstein's (2009) pervasive postpartum depression model proposed that relational processes occurring after women experience incongruence with social constructs of motherhood have the potential to lead to feelings of incompetence and shame and then isolation which, if not buffered by a supportive reaction from others, leads to postpartum depression. In this same study, Knudson-Martin and Silverstein discussed the need for preventative efforts attempting to curtail the instances of PPD in women to include attention to the ways in which the societal construct of mother (and fatherhood) limit women and men's flexibility in their roles as parents. Any efforts to offer help to families affected by PPD should promote helping individuals identify and expand the internalized social constructs of parenting and encourage more widespread acceptance of the wide range of emotions and experiences regarding parenthood. The question posed by this study, however, asks what women's current relationship to these societal constructs of motherhood is? Is it a tenuous relationship, reluctant acceptance of the role society wants women and men to play? Or, does the construct facilitate a deeper personal meaning for women, making it more difficult when they fall short of the construct's expectations?

This study seeks to understand the relationship that women who have experienced or are currently experiencing postpartum depression have with their perceptions about the social construct of motherhood. The study will ask how women's experience of motherhood and postpartum depression was influenced by and has subsequently influenced or modified the

personal meaning, or construct, they bring to being a mother. Secondly, the study poses a question to these women and asks if and how they would like to see the social perceptions of motherhood change after having experienced PPD. The study will focus on the experience of incongruence between lived experience and women's perceived social constructions of motherhood, how this incongruence impacts the experience of postpartum depression, and how it relates to women's feelings concerning what it means to be a mother. In order to focus on women's perceptions of societal views and their own motherhood experiences, a phenomenological method will be employed to further explore the model proposed by Knudson-Martin and Silverstein (2009).

Data will be collected from a focus group comprised of women seeking help from support groups and other treatment modalities for PPD. To help minimize the time commitment and need for childcare involved with participating in a study, the women will be recruited from and interviewed during an existing support group for women with PPD if possible. Women in various stages of diagnosis and treatment will be accepted into the study, in an attempt to capture a fuller picture of women's journey throughout the cycle of PPD. Studying women who have had PPD in the recent past or who are in later stages of treatment could provide researchers with useful information regarding the process by which women resolve their struggle between their experiences of incongruence with the social construct of motherhood. Women in treatment may also be more capable of giving complex insight into the processes that they personally experienced during PPD than they would have at the time of their diagnosis. Because the construct of motherhood is an abstract societal idea that individuals experience and perceive differently, a focus group modality allows women to discuss ideas about the social constructs of motherhood in a collaborative manner, allowing for discussion on the perceptions of the social

constructs of motherhood and consensus on the desired future of this interpretation.

Theoretical Framework

The problem will be examined from a cognitive dissonance and phenomenological lens. Cognitive dissonance proposes that dissonance is the uncomfortable state that exists when an event fails to produce the cognitive element that was expected. Dissonance has the most impact when the expected element is related to one's self-concept (Greenwald & Ronis, 1978). This theory helps to explain why the incongruence between women's perceptions of social constructs of motherhood and their experiences can cause distress for women as incongruence is especially distressing when the dissonance relates to one's concept of personal worth.

Cognitive dissonance is one way to conceptualize what Knudson-Martin and Silverstein (2009) described as incongruence between social constructs and experiences of motherhood. According to this theory, women who do not experience motherhood as their perceived social construct dictates may experience distress, especially if this incongruence is interpreted as a negative reflection of their success as a mother. Additionally, if women's negative feelings and worries relating to their experience of postpartum depression and being a mother is a further deviation from the perceived ideal mother, it leads to more distress. Mauthner's (2009) article title succinctly captured the experience of this cycle with a quote from one of her study participants: "Feeling low and feeling really bad about feeling low."

A phenomenological framework serves to conceptualize what meaning women ascribe to being a mother in light of their experience of incongruence within their perceived societal framework for motherhood. Phenomenology concerns itself with the philosophical importance of lived experiences and implies that the meaning an individual ascribes to their lived experiences provides the most truthful interpretation of the phenomenon (Creswell, 2007). The

phenomenon is examined from the interpretation of the participant, while the researcher takes a neutral stance in the research. It is the role of the researcher in this transcendental phenomenological framework to report on the experiences the participant describes, rather than interpret them from the researcher's perspective (Cresswell, 2007).

Purpose of the Study

This study focuses on what Knudson-Martin and Silverstein (2009) described as the incongruence between societal constructs of a good mother and women's real experiences. More specifically, it seeks to understand how women's experience of this incongruence, in turn, affects the meaning they ascribe to motherhood in relation to their perceived societal construct of motherhood and if and how they would want to see this construct changed. Using a phenomenological approach, this study seeks to understand the following:

- What are women's experiences with incongruence between perceptions of societal constructs of being a good mother and their own experience of motherhood and postpartum depression?
 - What ideas or models did they use to build their perceptions of these social constructs?
 - What reaction did they have to the incongruence?
- What meaning do women ascribe to motherhood after having experienced postpartum depression?
 - How does the experience of having postpartum depression, within the context of perceived societal messages about being a good mother, play a part in forming what it means to be a good mother?

- How does experiencing postpartum depression inform the way women would like to see perceptions of societal constructs change?
 - What, if any, information about the experiences of being a mother or experiencing postpartum depression would they wish were more prevalent in media, popular culture, and the medical field?

Chapter 2: Literature Review

Most research devoted to the study of postpartum depression is concerned with the prediction, detection, and prevalence of the disorder (Beck, 1996a; Dietz, et al., 2007; Field, et al., 1985; Howell, et al., 2009). However, recently a small but growing body of literature has turned its focus to understanding how women experience postpartum depression, proposing similar processes of worsening despair, incongruent expectations of motherhood, isolation, and feelings of failure (Beck, 2002; Knudson-Martin & Silverstein, 2009; Mauthner, 1999). These studies both describe the experience and attempt to make sense of the mechanisms that sustain postpartum depression. Additionally, research on the broader topic of social constructs of motherhood provides a cultural context from which to examine the distress associated with postpartum depression (Choi, et al., 2005; Cowdery & Knudson-Martin, 2005). The role that social constructs of motherhood play in perpetuating feelings of incompetence and guilt is a common theme that arises out of the study of women's experiences, but is rarely the focus of study (Beck, 2002; Knudson-Martin & Silverstein, 2009; Mauthner, 1999).

Predictors and Variables of Postpartum Depression

In 1985 Field, et al, compared the postpartum experiences of two groups of twelve women based on their answers to a questionnaire taken during their third trimester. The questionnaire aimed to separate women who were having "personal problems" during pregnancy from those who were not and predicted women in the "personal problems" group would have a higher instance of PPD. Women who experienced personal problems during their pregnancy, such as not having a partner, having marital problems, unexpectedly becoming pregnant, not wanting to have a child, or having a history of previous depression following childbirth, experienced significantly higher rates of depression at 3 to 5 months. This group of women were

more likely to show high state and trait anxiety ratings and interactions with their infants showed less activity, more flat or tense facial expressions, less game play, and a predominantly depressed or anxious looking state. The research presented by Field, et al. suggested personal problems played a role in the prediction and risk for women's development of postpartum depression.

In 1996, Beck performed a meta-analysis on 44 studies that focused on identifying predictive factors of PPD predictive factors in an effort to form a more comprehensive understanding of the magnitude of the relationship between PPD and predictive variables. Beck analyzed the relationship between postpartum depression and eight predictor variables, finding prenatal depression to have the strongest effect size, followed by child-care stress, life stress, and then social support. Maternity blues, marital satisfaction, prenatal anxiety, and previous depression not associated with pregnancy were also found to predict PPD (Beck, 1996a).

Dietz, et al. (2007) performed an analysis of women with a diagnosis of PPD using data collected from a large health insurance company. After determining the total number of live births within the selected parameters, researchers identified the number of women with a recorded diagnosis of postpartum depression. Of women with eligible pregnancies, 10.4% of women experienced depression during the 39 weeks postpartum. Of these 10.4%, over half also experience depression during pregnancy. Women who were more likely to experience postpartum depression at any time between 39 weeks prior to becoming pregnant and 39 weeks after giving birth were white, unmarried, had 3 or more children from previous pregnancies, and had health coverage through Medicaid. This study again suggests a link between postpartum depression and the emotional strains under which a woman is becoming pregnant and giving birth.

In a 2009 study, Howell, et al. sought to determine modifiable risk factors for PPD by

interviewing over 550 mothers at 2 and 6 weeks postpartum. They found women suffering from depression at both time 1 and 2 were more likely to be non-white (a finding contrary to the findings of Dietz, et al. (2007)), unmarried, and earn an annual income below \$30,000, compared to their counterparts that did not develop postpartum depression. Results showed a positive correlation between past depression, inadequate social support, and situational triggers (such as a colicky infant or physical ailments following childbirth) and depressive symptoms during the postpartum period. Additionally, Howell, et al. noted that high levels of social support may act as a buffer against PPD for women who are also experiencing other situational risk factors.

Experience of Postpartum Depression

Research into the risk factors associated with postpartum depression consistently point towards social and emotional factors (i.e. social support, past depression) as playing a role in the likelihood that a women may develop PPD (Beck, 1996a; Dietz, et al, 2007; Field, et al., 1985; Howell, et al., 2009). What these studies cannot show us is the process by which these social and emotional factors affect women after childbirth. To understand more about what the role of these experiential factors play in the development of PPD, research turned to methods that could capture the experience of having PPD.

In a second 1996 study, Beck employed a phenomenological method to study the experience of 12 married women suffering from postpartum depression. Nine theme clusters emerged from Beck's study; (1) women described PPD depriving them of any feeling of joy and even the desire to interact with their children; (2) women were overwhelmed by their responsibilities and feared they would not be able to cope, describing PPD as something that had taken over, or even "possessed" them; (3) women separated themselves physically and emotionally from their children; (4) women often failed to respond to the infant's bids for

interaction; (5) women experienced constant guilt and irrational thinking and (6) sometimes-uncontrollable anger; (7) women worried that PPD was damaging their relationship with their older children and robbing them of the intimacy they wanted with all of their children; (8) women experienced a pervasive sense of loss surrounding their relationships with their child, yet despite overwhelming despair and guilt; and (9) women still constantly strived to put their children's needs above their own (Beck, 1996b).

Beck's findings are echoed in Mauthner's 1999 qualitative study on motherhood and postpartum depression. Mauthner sought to understand how women experienced postpartum depression and how PPD played a role in other areas of their life, specifically within their interpersonal relationships and expectations regarding motherhood, while trying to gain an understanding of the process through which women became depressed. Mauthner interviewed eighteen British women affected by PPD that described debilitating symptoms that affected them both physically and psychologically. These women strongly identified with the label "postpartum depression" as they wanted to be able to distinguish their feelings from simply feeling "low" or "sad" and emphasize the severity of distress they felt. As in Beck's (1996b) study, women felt consumed by PPD and could not recognize the person they had become.

Women in Mauthner's (1999) study also noted experiencing conflict between expectations and the actual experience of motherhood. While women's particular cultural construct of an ideal mother was not specified and the women could identify their perceived ideal as unobtainable, it was the universal expectation that they should be, yet were not able to cope with the reality of motherhood that seemed to cause them the most distress. Mauthner (1999), in the process of exploring the relational aspects of PPD, also identified societal constructs as a key part in the experience of PPD, which would then be echoed in Beck's 2002

and Knudson-Martin and Silverstein's 2009 analyses.

Knudson-Martin and Silverstein (2009) described several repeating themes in the qualitative studies used in their meta-analysis of PPD related studies. The nine qualitative studies conducted on participants from diverse backgrounds and countries, including India, Hong Kong, England, and African American women from the United States, described similar experiences with the processes that led to and worsened PPD. Women recounted experiences of a worsening, progressive despair that made child care tasks difficult and profound feelings of disconnection from family, friends, and their own sense of self. Contrasts between the perceived socially constructed ideas of motherhood and personal experience were expressed in nearly all the studies Knudson-Martin and Silverstein examined. Women feared that by not living up to the expectations they had had about being a mother, they would necessarily be judged by others as a "bad" mother. In part because of this fear, and because the feelings of inadequacy felt deeply shameful, women found themselves unable to express to others the struggle they were facing. Outright negative or even dismissive responses to women's struggle to keep up with their various role-related tasks further pushed women into isolation.

Social Constructs of Motherhood

Specific perceptions of social constructs of motherhood vary from culture to culture and even within the cultures from family to family. While the ideal mother portrayed by media, advertising, and cultural legacy may differ around the world, what is described globally is an inability for women to live up to the ideal mother their culture dictates. In understanding postpartum depression, the specific beliefs of what makes an ideal mother are not as important as recognizing that society places immense pressure on women to live up to the ideal. Despite the vast differences in social constructs, at least two common themes regarding motherhood tend

to surface among different studies. One, being that mothering is a task in which women have a gendered superiority; the idea that women have a “natural” ability to care for children and meet their needs (Choi, et al., 2005; Cowdery & Knudson-Martin, 2005). Secondly, women communicate that they feel they are led to believe that motherhood is inherently fulfilling, happy, and joyous at all times (Beck, 2002; Knudson-Martin & Silverstein, 2009; Mauthner, 1999).

Mothering as a gendered task. One myth of motherhood is the belief that mothering is a gendered task, favoring women as biologically superior caretakers. This belief supports traditional gender roles within the family, which help maintain unequal division of childcare tasks and place much of the responsibility on the mother. Cowdery and Knudson-Martin (2005) analyzed interviews from 50 couples and compared those couples that viewed mothering as a gendered talent with those who saw mothering tasks as a conscious collaboration. Results of this study suggested that couples that believe women are not only physically, but also emotionally more equipped for nurturing children place more emphasis on mothers to maintain a bond with children. According to the findings, as a response to this belief, the fathers stepped back from intensive bonding and caretaking activities, leaving women in charge of nearly all aspects of practical and emotional childcare tasks. Thus, the children of these couples responded less to their fathers as a bonded caretaker, leaving the mothers to take on the responsibility of bonding and caretaking in its entirety. The study also noted that within this group, women arranged their time and lives around being the primary provider of child care while men retained their free time as they had before becoming a parent. The couples that maintained this separation of roles were not always conscious to do so and did not necessarily believe in strongly separated gender roles. They did however, begin with the belief that women are naturally more inclined to care for children (Cowdery & Knudson-Martin, 2005).

Cowdery and Knudson-Martin's second group of couples, who believed childrearing was a shared responsibility, distributed childcare tasks and relational connection with children more equally between the two parents. Fathers in this second group did not believe they were limited by biology in their ability to help with childcare and connect with their children, and thus they took on bonding and caretaking tasks on their own without the interference or direction of mothers. These families shared the responsibilities of childcare when they concluded that women did not possess unique child rearing capabilities beyond that of a father's. Cowdery and Knudson-Martin found that this alternative to the myth that mothers are naturally ready to parent helped couples promote a shared responsibility of the emotional and physical demands and delights of parenthood.

In Choi, Henshaw, Baker, and Tree's (2005) study, women reported the realization that childcare did not come naturally to them was overwhelming and terrifying. This study of twenty-four United Kingdom mothers sought to understand how women understood their experience as mothers in relation to their societal ideals concerning mothering. These women indicated a notion that they would and should be able to immediately take on and excel at the mothering role, but instead found themselves unprepared for both the practical tasks of childcare and the all-consuming nature of the mother-role. When mothers realized their experience was veering away from the societal ideal, feelings of inadequacy became common. Not only did women believe motherhood should come easy and naturally, when it didn't, women believed they *should* be able to cope with it anyway. Women experienced a double blow from feelings of inadequacy; first when their experience did not match up to their perceived ideal, and again when they interpreted their distress from this incongruence as just another instance of their inability to be a good mother (Choi, et al., 2005).

The myth of motherhood: Unrealistic expectations. Beck's 2002 study highlighted the unrealistic expectations mothers held prior to entering motherhood and the conflict experienced when they perceived the incongruity as a sign of their failure as mothers. The 18 qualitative studies used in the meta-analysis all originated from western nations; the United States, Canada, United Kingdom, and Australia; and included participants from western Caucasian, Middle Eastern, African, and Asian ethnic backgrounds. The meta-analysis revealed similar experiences of conflicting expectations in women from varied cultural backgrounds though, it seems that while cultural expectations for mothers may vary in intensity and context from culture to culture, women everywhere can experience internal conflicts when their experience falls short of the idealized version of motherhood they have come to expect. The analysis of studies suggests one way that women attempt to reconcile this conflict is by determining that the incongruence and distress they are experiencing is attributed to their own failure as a mother. Furthermore, women describe feeling that as a "good mother" they should be able to cope with the stress and demands of being a mother. It is this expectation that they should be, yet are not able to cope with the reality of motherhood that seems to cause the most distress (Mauthner, 1999).

Choi, et al, (2005) found that for most participants, motherhood in practice was far from the ideology of motherhood that many of these women had come to expect. The societal ideals that these women were raised in, taught them that motherhood would always be a joyful experience and that they would instinctually be equipped to care for an infant. The women were surprised when their experience of mothering was unlike the mythic ideal; they found themselves unhappy at times, overwhelmed, unprepared, and exhausted. These women also found themselves unprepared for the all-consuming nature of motherhood and the stress placed on them by the expectation that good mothers are completely selfless. Again, the distress that arose from

finding motherhood to be unlike the societal ideal came largely from women believing that they were unable to cope with motherhood and that in itself made them a bad mother.

Mauthner's (1999) noted in her study that despite the acknowledgement that the ideal mother was a fantasy, women experienced much difficulty in relinquishing their beliefs surrounding what they "should" be doing as mothers. Although many women reported fears of being labeled a failure in the eyes of the motherhood ideology, women did not indicate they were seeking other explanations of motherhood. Instead, it seemed the participants tried even harder to live up to an impossible ideal. Mauthner discussed that without a viable alternative, the culturally prescribed "right way" is constantly being reinforced through interactions with family members and health professionals. When attempting to express their distress over motherhood, these women failed to receive support surrounding their experience or became so fearful of their feelings being rejected that they remained silent and withdrew from the relationships around them (Choi, et al., 2005).

Looking for Processes that Sustain Postpartum Depression

Inconsistencies between perceived societal constructs and real experiences of motherhood are the starting point for many of the interpersonal theories proposed in postpartum depression studies. According to these studies, as women experience incongruence between their expectations and reality, they experience feelings of failure, incompetence, helplessness, and isolation. Incongruence with their ideal model of motherhood leads to self-judgment and fear (Beck, 2002; Knudson-Martin & Silverstein, 2009; Mauthner, 1999). Mothers with postpartum depression often attribute their inability to live up to social constructs of motherhood to their own inadequacies (Beck, 2002; Knudson-Martin & Silverstein, 2009; Mauthner, 1999).

In studies by Mauthner (1999), Beck (2002), and Knudson-Martin and Silverstein (2009),

women's perception of a contrast between experienced motherhood and the cultural ideal reportedly led to an internal crisis. This crisis heightened quickly when women reportedly believed their personal distress was due to their own weakness or failure as a mother. Some women came to this conclusion after finding they were unable to share these negative feelings with others due to lack of validation or simply for fear of how others would react. The perception of the ideal motherhood construct of their culture was reinforced by others who downplayed the woman's experience or confirmed her fears and attributed her negative experience to the woman's own inadequacy as a mother (Mauthner, 1999). Women in these studies began to isolate themselves as they avoided turning to family members or friends for support, citing feelings of shame for not experiencing motherhood, as they believed they "should". Depression was maintained as the isolation and negative feelings continuously failed to lead to a validating and supportive reaction from others (Knudson-Martin & Silverstein, 2009).

Mauthner's 1999 work described an early synthesis of the processes that could lead to PPD. Each woman in Mauthner's study experienced a sense of conflict between what kind of mother they believed they should be and what they believed they actually were. Mauthner observed that the women, although all having come from a shared cultural background, each developed unique ideas about what it meant to be a good mother and what kind of mother they should strive to be. As women struggled to meet their own ideals, they actively silenced themselves to hide their perceived failures as mothers, and thus moved into a state of isolation from the relationships around them. This isolation, Mauthner said, was the link to their depression (Mauthner, 1999).

Unique to Mauthner's work on the processes involved with PPD was her attempt to

answer the question why some women develop PPD while others do not (1999). While Mauthner's interviews suggested that women who didn't develop PPD did not experience conflict between expectations and experiences of motherhood, she rejects this as a viable answer to the question. Rather, Mauthner posited that it was more likely that the inner conflict caused by the idealized good mother was a common experience for women, but that mothers who did not become depressed were perhaps better able to resolve the conflict without isolating themselves. Mauthner suggested these women not affected by PPD may have been able to accept their feelings or modify their perception of a "good" mother in a way that did not make their feelings shameful or were able to voice their negative feelings and received non-judgmental or non-minimizing responses. In doing so, Mauthner made the suggestion that the development of PPD may hinge not on the experience of cultural conflict itself, but on the relationship that women have with that perceived cultural construct of motherhood; their ability to modify their ideas of mothering and accept their experiences. Their resolution to this conflict would also depend on an environment in which they could accept their feelings and discuss them within a responsive and non-judgmental context (Mauthner, 1999).

In addition to highlighting women's conflict between the cultural constructs of motherhood and the experiences of motherhood, Beck's 2002 synthesis of qualitative studies identified four overarching themes, or perspectives, present in the accounts of women's experience with PPD. Unlike the procedural theory presented in the later works of Knudson-Martin and Silverstein, Beck described her synthesis qualitative data through a more circular and fluid model. Women could move back and forth between perspectives, and occupy more than one perspective at a time. The four perspectives described were: the experience of incongruence between unattainable expectations of motherhood and reality, spiraling downward, pervasive

loss, and making gains (Beck, 2002).

Beck's findings illustrated the downward spiral into postpartum depression as a process involving a constellation of symptoms and emotions (2002). These constellations of symptoms were unique for every case and could be comprised of any combination involving feelings of anxiety, overwhelming responsibility, obsessive thinking, anger, isolation, guilt, and even suicidal thoughts. Women's experience of pervasive loss included women's loss of control and personal autonomy, loss of self, and loss of relationships, between mothers and their infants, older children, and partners. The final theme, making gains, described aspects of women's recovery from postpartum depression. The shame and fear of stigma associated with postpartum depression made seeking help a monumental step for women to take. Recovery required, before any treatment could occur, that women surrender. Surrendering, in this sense, meant recognizing that they needed to seek help and that something was seriously wrong (Beck, 2002).

In 2009, with the goal of understanding PPD from a relational context, Knudson-Martin and Silverstein used grounded theory to propose a common set of relational processes and introduce a model for these processes. Their research noted that across cultural contexts, women's struggle with postpartum depression involved silencing themselves regarding negative feelings, as they were not congruent with the societal constructs of motherhood. The process of silencing themselves led to isolation as they experienced feelings of incompetence and difficulty maintaining connection with others. Similar to Mauthner's suggestion in her 1999 study, Knudson-Martin and Silverstein's processes implied that resolving the incongruence between the perceived social constructs of motherhood and experience was a common task for mothers. Women became isolated only when they interpreted their incongruence as incompetence or when they were unable to make a connection with others in regards to expressing their negative

experiences surrounding motherhood. In their research, Knudson-Martin and Silverstein (2009) proposed that regaining connection with others and promoting the safe expression of negative emotions about mothering would help women to “make it through” PPD.

Conclusion

A breadth of research has been devoted to the understanding of risk factors, possible predictive variables, and prevalence of postpartum depression in women (Beck, 1996a; Dietz, et al., 2007; Field, et al., 1985; Howell, et al., 2009). In recent years, researchers have also turned their attention to better understanding the experience of women with PPD by employing qualitative research methods and interviewing women directly (Beck, 1996, Beck, 2002; Knudson-Martin & Silverstein, 2009; Mauthner, 1999). It is the opinion of this researcher that better understanding of the experience of PPD not only helps to form ideas and theories about the processes that contribute to PPD (Beck, 2002; Knudson-Martin & Silverstein, 2009; Mauthner, 1999) but also emphasizes, in emotional and personal terms, the substantially detrimental effects PPD has on the lives of women and thus the need to better understand it. While these studies have introduced the idea that perceptions of societal constructs of motherhood could play a role in postpartum depression, none have yet focused directly on the relationship between the perceived constructs of motherhood, postpartum depression, and the women it affects. This study seeks to explore the phenomenon of incongruence experienced by women suffering from PPD and how women view, experience, and wish to relate to these perceived constructs of motherhood.

Postpartum Depression and the Meaning of Motherhood:

Exploring the Role of Contrast and Expectations

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Abstract

Postpartum depression affects between 10 - 15% of all mothers within the first year after giving birth (Dietz, 2007; Epperson, 1999). Studies that have focused on women's experiences of postpartum depression have found similar in experience of contrast between women's expectations of motherhood, and their actual experiences (Beck, 2002; Knudson-Martin & Silverstein, 2009; Mauthner, 1999). Using a phenomenological approach, this study sought to further understand women's experiences of contrast, to explore how this experience contributed to their social construction of what motherhood meant to them, and to ask if and how women might change the messages that they receive regarding being a mother.

Seven women were recruited from a postpartum depression support group and interviewed in a focus-group setting. Respondents noted that they experienced a great contrast between their expectations of motherhood and what they actually experienced. These expectations, however, seemed ambiguous and generic. Women reported that they were surprised by the amount of judgment and pressure they felt surrounding being a mother. Participants seemed to challenge their preconceptions about being a mother by focusing on making choices that were best for them and their children and by allowing unhappy feelings to be compatible with their definition of a good mother. Women in the study described wanting to hear messages that were honest and open about the realities of motherhood, both from the media and in their interactions with other women and loved ones. Participants also seemed to feel strongly that more efforts should be made to reach out to new mothers.

Introduction

Postpartum depression affects nearly 10-15% of women within the first year after giving birth (Dietz, 2007; Epperson, 1999). Cases of postpartum depression (PPD) often go undiagnosed, as some symptoms can be difficult to distinguish from the telltale markers of new parenthood such as fatigue and loss of sleep. Postpartum depression is diagnosed using the same criteria for major depressive disorder as outlined in the fourth edition of the American Psychiatric Association's Diagnostic and Statistical Manual (2000), and therefore symptoms of postpartum depression are similar to those typical of major depressive disorder such as insomnia, feelings of worthlessness, and loss of concentration. In PPD, however, most feelings of helplessness and failure are associated with performing the motherhood role (American Psychiatric Association, 2000; Epperson, 1999; Harvard Medical School, 2011). These feelings of failure add to the already stressful responsibilities and adjustments of parenthood.

The impact of postpartum depression on women's lives is not isolated to the Western world. Women across racial and cultural boundaries report experiencing postpartum depression in much the same way, citing isolation, invalidation, and a spiraling depression (Beck, 2002; Gao, Chan, You, & Li, 2009; Knudson-Martin & Silverstein, 2009). In most cultures, postpartum depression carries with it a specific stigma and guilt apart from the regular stigma of mental illness (Knudson-Martin & Silverstein, 2009). Motherhood still defines the social construct of a feminine identity for cultures around the world, and everywhere societies have many ideas and ideals about what a mother should be. Societies are critical of how, and stigmatizing of how well, a woman can perform her duties to her children (Medina & Magnuson, 2009). This social stigma may contribute to delayed detection of PPD and a prevalence of less than half of women with the disorder seeking treatment (Epperson, 1999; Harvard Medical,

School, 2011).

The causes of postpartum depression are unknown, however, known predictive factors can help identify women who may be at a higher risk. Predictive factors for postpartum depression include previous episodes of depression (particularly during the prenatal period) childcare stress, life-stress, and lack of social support (Beck, 1996). While no factors have been found to have a definitive causal link to PPD, higher levels of social support have been shown to buffer against PPD for women who have previously experienced episodes of depression (Howell, Mora, DiBonaventura, & Leventhal, 2009). Although hormonal fluctuations may help to explain women's predisposition to emotional instability after childbirth it is not a complete explanation (Harvard Medical School, 2011). Recent qualitative studies on the personal experiences of women with PPD have further expanded our understanding of postpartum depression to include ways in which relational processes and societal ideals help to sustain postpartum depression (Beck, 2002; Knudson-Martin & Silverstein, 2009; Mauthner, 1999).

Postpartum depression is mainly studied from a medical model and is rarely examined from a systemic lens. However, researchers that have focused on the experiences of women with PPD have discovered similar systemic processes that seem to span across different ethnic groups and socioeconomic groups. These studies describe processes of isolation, worsening distress, and withdrawal that center around women's distress over new motherhood and the shame they carry for not living up to the ideal social construct of a good mother (Beck, 2002; Kudson-Martin & Silverstein, 2009; Mauthner, 1999).

A Relational Model for Postpartum Depression

Inconsistencies between perceived societal constructs and real experiences of motherhood are the starting point for many of the interpersonal theories proposed in qualitative

postpartum depression studies. According to these studies, as women experience incongruence between their expectations and reality, they experience feelings of failure, incompetence, helplessness, and isolation (Beck, 2002; Knudson-Martin & Silverstein, 2009; Mauthner, 1999). Incongruence with their ideal model of motherhood leads to self-judgment and fear. Mothers with postpartum depression often attribute their inability to live up to social constructs of motherhood to their own inadequacies (Beck, 2002; Knudson-Martin & Silverstein, 2009; Mauthner, 1999).

In studies by Mauthner (1999), Beck (2002), and Knudson-Martin and Silverstein (2009), women's perception of a contrast between experienced motherhood and the cultural ideal reportedly led to an internal crisis. This crisis heightened quickly when women reportedly believed their personal distress was due to their own weakness or failure as a mother. Some women came to this conclusion after finding they were unable to share these negative feelings with others due to lack of validation or simply for fear of how others would react. The perception of the ideal motherhood construct of their culture was reinforced by others who downplayed the woman's experience or confirmed her fears and attributed her negative experience to the woman's own inadequacy as a mother (Mauthner, 1999). Women in these studies began to isolate themselves as they avoided turning to family members or friends for support, citing feelings of shame for not experiencing motherhood, as they believed they "should". Depression was maintained as the isolation and negative feelings continuously failed to lead to a validating and supportive reaction from others (Knudson-Martin & Silverstein, 2009).

Mauthner's 1999 work described an early synthesis of the processes that could lead to PPD. Each woman in Mauthner's study experienced a sense of conflict between what kind of

mother they believed they should be and what they believed they actually were. Mauthner observed that the women, although all having come from a shared cultural background, each developed unique ideas about what it meant to be a good mother and what kind of mother they should strive to be. As women struggled to meet their own ideals, they actively silenced themselves to hide their perceived failures as mothers, and thus moved into a state of isolation from the relationships around them. This isolation, Mauthner said, was the link to their depression (Mauthner, 1999).

Unique to Mauthner's work on the processes involved with PPD was her attempt to answer the question why some women develop PPD while others do not (1999). While Mauthner's interviews suggested that women who didn't develop PPD did not experience conflict between expectations and experiences of motherhood, she rejects this as a viable answer to the question. Rather, Mauthner posited that it was more likely that the inner conflict caused by the idealized good mother was a common experience for women, but that mothers who did not become depressed were perhaps better able to resolve the conflict without isolating themselves. Mauthner suggested these women not affected by PPD may have been able to accept their feelings or modify their perception of a "good" mother in a way that did not make their feelings shameful or were able to voice their negative feelings and received non-judgmental or non-minimizing responses. In doing so, Mauthner made the suggestion that the development of PPD may hinge not on the experience of cultural conflict itself, but on the relationship that women have with that perceived cultural construct of motherhood; their ability to modify their ideas of mothering and accept their experiences. Their resolution to this conflict would also depend on an environment in which they could accept their feelings and discuss them within a responsive and non-judgmental context (Mauthner, 1999).

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The Present Study

This study focuses on the contrast between societal constructs of a good mother and women's real experiences. More specifically, it seeks to understand how women's experience of this contrast, in turn, affects the meaning they ascribe to their socially constructed perceptions of motherhood and if and how they would want to see this construct changed. Using a phenomenological approach, this study seeks to understand the following:

- What are women's experiences with their expectations of motherhood and their actual experience of motherhood and postpartum depression?
- How does experiencing postpartum depression change the meaning women attribute to being a good mother?
- How does experiencing postpartum depression inform the way women would like to see the social construction of motherhood change?

Methods

A phenomenological approach was used to interview seven women in a focus group setting. Phenomenology, which concerns itself with the philosophical importance of lived experiences, allows us to focus on the meaning women ascribe to being a good mother. By approaching women's experience through a phenomenological lens, the focus of inquiry is examined through inductive exploration of women's own interpretation of postpartum depression and motherhood (Creswell, 2007).

The focus group method of data collection is unique among interview methods in that interactions do not take place only between the interviewer and the participant, but amongst the interview and a group of participants. A focus group is used to elicit feelings and opinions about a central issue or topic from the participants, using the interactions between participants to add richness and breadth to the interview content. Focus group moderators pose open-ended interview questions to the participants as a means of igniting discussion surrounding the central issue and to gain more understanding about the issue (Krueger, 1994). Because of the complex nature of the study questions, participants were provided with a list of prepared questions before the focus group was conducted. Additionally, the researcher asked pertinent follow up questions during the focus group session to further examine and define constructs that seemed to arise during the discussion.

Participants

Participants in the study were members of an existing support group for women experiencing postpartum depression that was run by a licensed counselor who had also experienced postpartum depression. Criteria for participation in the study excluded women who had used invasive fertility treatments prior to becoming pregnant or mothers of children with

serious developmental or health issues. Women in the study were recruited by contacting support group leaders within a network of PPD support groups in the greater Washington, D.C. area. Recruiting participants through their support group and using their regular meeting time to conduct a focus group interview ensured that participation in this study required a minimal time commitment on the part of the participant.

Participant ages ranged from 31 to 41 and all women in the study indicated they were married (see table in Appendix A). Six of the seven participants identified themselves as Caucasian except for one woman who identified herself as Hispanic. All participants reported that they either currently worked full-time or part-time outside the home or intended to return to work full-time in the future. Additionally, participants in this study represented a highly educated group of women; five held a master's or more advanced degree and two held a bachelor's degree.

The seven study participants were at various stages in their experience with postpartum depression. Most participants had recently given birth and were seeking help for their struggle with postpartum depression. However, a few mothers were involved with the support group as a means of receiving sustained, long-term support for PPD. One of the seven participants experienced personal health complications after giving birth. Four of the seven women had given birth within the last 24 months, with the most recent having given birth thirteen weeks prior to the focus group. Two women had given birth three years prior, and the support group leader had given birth seven years prior. Six of the seven participants experienced postpartum depression after having their first child, however one of the participants experienced PPD only after giving birth to their second child. Of these six women, two of them had a second child at home. Support group membership ranged from members visiting the support group for the first

time to members who had been attending the group for 18 months. Women who participated in the support group did not have to have a formal diagnosis of postpartum depression, however most of the women in the group indicated they were additionally under the care of a doctor or therapist for PPD.

Data Collection and Analysis

Participant data was collected during a 90-minute focus group interview. Participants were provided with a list of interview questions on the day before the focus group took place, however, occasionally the interviewer would ask follow up questions to further explore relevant themes as they emerged. Questions were asked in a way that would allow progression from evaluations of external, less personal constructs to internal, more personal constructs. This was done so as to help women ease into the conversation about their personal experiences with PPD. Questions related to the three aims of the study and focused on participants' experiences with incongruence, their definition of a good mother, and if and how experiencing postpartum depression changed participant's meaning of motherhood.

The focus group interview was recorded using digital video and audio equipment. Recordings were then transcribed and coded. The coding process began by utilizing an open coding method based on that described in Strauss and Corbin (1990). Transcripts were read and re-read until recurring ideas or codes began to form. Data analysis was continuously shared with a research partner to ensure reliability and validity of the findings. The resulting list of codes or recurring ideas was then examined to combine smaller sets of codes into larger ideas or themes. Eight themes emerged during the open coding process; postpartum depression symptoms, ill-structured expectations, judgment, perfection, finding their own way, unhappy in motherhood, talking honestly about motherhood, reaching out. Themes were then organized based on their

relevance to the three main purposes of this study. The theme “postpartum depression symptoms” was omitted from the results due to its incompatibility with the study’s purpose; to explore the experience and implications of incongruence in women’s experience of postpartum depression. From the remaining seven themes, a detailed description, capturing the essential nature of each theme, was constructed.

Results

The focus group interview questions were divided into three main categories that corresponded to the three main purposes of this study. First, respondents were asked to talk about possible contrasts between their expectations of motherhood and their actual experiences. Second, respondents commented on how they integrated their experience of contrast into their understanding of themselves as mothers. And thirdly, mothers noted areas in which they felt changes could be made to support women who experienced PPD.

The Contrast of Motherhood

When participants were asked about a possible contrast they experienced between what their expectations of motherhood were and what they actually felt after becoming a mother, they seemed to be easily able to express that a contrast existed, but were less certain of how to articulate the areas of contrast. Participant’s expectations of motherhood seemed to be difficult for them to articulate, however once becoming a mother they described being greatly surprised and overwhelmed by motherhood. Women described being unprepared for feelings of judgment by others and for feeling that they were failing at being a good mother.

In general, the participants described that their experiences of motherhood and postpartum depression stood in direct contrast to the expectations they held of motherhood before their pregnancy. In particular, women expressed that the contrast between believing

motherhood would be a joyful experience, but then failing to find the joy was very distressing. However, when it came to describing what it meant to be a good mother, mothers reported that they could not recall specific ideas regarding being a good mother before their pregnancy: “I honestly don’t think that I could put my finger on what my expectations were before [son's name]. I’m sure that I had them. Because I’m sure that they were dashed afterward.” While participants seemed to have specific expectation of what being a mother would feel like, their ideas regarding what a good mother *should* be, were unarticulated and impersonal. Their expectations of motherhood seemed non-specific and ambiguous ideas of what motherhood would be like.

Despite feeling unable to articulate their expectations before becoming pregnant, women did seem to be able to describe what their ideas of being a good mother had been by drawing on examples of motherhood given by their own mothers and family members.

“I was raised by a single mom so, that was my, I don’t know, vision, not to be a single parent, but I mean... how she dedicated so much to her kids and that’s what I thought being a good mom was.”

Although women mentioned the influence of their mothers’ examples, they also described having little understanding of what the emotional difficulties of being a mother would mean to them.

Despite these ambiguous expectations, after giving birth, mothers reported being surprised by the amount of judgment they felt from societal messages, the media, and other women. Participants reported feeling pressured to live up to an ideal standard of prescribed “good motherhood” and found they also received conflicting messages about how to care for their child in order to become a good mother. “We have too much right and wrong, right now.

Like this is right and this is wrong, and the next day, this is wrong and this is right.” The sense of judgment and constant comparison to other mothers also seemed to contribute to an amplifying loop related to the women’s drive and experience of being successful and perfect in their pursuits.

Although participants had not created developed definitions of their expectations for what motherhood would be like, they reported that they believed they would be successful as mothers.

I just thought that I would be able to do it better or differently than everyone else cause I’m a perfectionist, or you know, whatever, really high expectations. Like, well, you know, they’re struggling with this and maybe it’s because of that and it won’t be that way for me.

The previous experience of these women in difficult situations had been that their hard work and perfectionism would allow them to succeed. This desire to be the “perfect mother” seemed to increase mother’s attunement to the judgment and comparison from other mothers and internalized expectations of being a mother. As women became more attuned to the judgment involved with being a mother, it appears their emotional need to be a successful and perfect mother became greater.

Ambiguous expectations. When women were asked to describe their preconceptions regarding motherhood, they seemed to have difficulty recalling thoroughly developed expectations before pregnancy of what motherhood would be like. Although before pregnancy they were confident that motherhood would be “hard”, they did not seem to have a sense of what this meant for them on an emotional or physical level. One woman explained: “I did know it would be hard. I mean, okay, changing diapers, and they cry and stuff, yeah I get it. But I didn’t *get it.*” Participants clearly had *some* expectations of what their motherhood experience would

be. They reportedly expected themselves to be successful and happy with their experiences. Women seemed to feel confident about their ability to deal with being a mother, however they had not fully personalized how they would respond to the demands of motherhood. Although these expectations existed, they were ambiguous and generalized.

Generic expectations that they would be capable of taking care of their children and coping with the demands of motherhood seemed to provide more contrast against reality than expectations about what a good mother should be or do. Women's experience of contrast seemed to be greatly affected by the expectation that motherhood would be happy and joyful. However, for these participants who experienced PPD, they felt this expectation did not hold true: "I expected it to be hard but I didn't expect it to be not — there was no happiness around it and so that was very surprising and hard ... devastating, to deal with." Another mother described feeling disillusioned during her pregnancy, having expected that she would enjoy being pregnant but finding herself struggling with depression instead: "I would cry when I was pregnant and say, 'I don't understand why I don't like this.'"

Mothers did not seem to have prepared themselves for how they would deal with the demands of motherhood or articulated ideas regarding what kind of mother they would be. The models available for women to create expectations of motherhood were often their own mothers, whose examples were idealized and lacked the full picture of their mothers' experiences:

And so actually, as I was pregnant, that kind of started. Just like as I said, how, if I think my mom's a good mother and she stayed home, how can I be a good mother if I'm not going to stay at home?"

Women felt they had few examples or models to turn to that could exemplify modern motherhood:

I think my mom is the closest example that I have because a lot of my best friends who are in D.C. don't have children yet...So then, getting ready to go back to work, I don't really know how it works yet. You know, I feel like my friends who are full-time working moms are so busy I barely have time to connect with them and talk to them and so I don't really, you know, I don't know what it's like.

Participants' responses suggest that perhaps they hadn't needed to develop expectations past a generalized stage because none of the women's expectations included the possibility that motherhood would be a distressing experience. One woman's account of her expectations depicted a generalized notion that whatever motherhood could bring, she would be able to handle.

I think my expectation of what it meant to be a good mother during pregnancy were the same as my expectations of everything else in my life up to that point, which was that it was going to be perfect. And it wasn't.

This participant also described the contrast between expectations and experience as being a part of the cause of her PPD: "I feel like the contrast between what I was prepared for and what actually happened is what pushed me over the cliff into the depression and the anxiety." However, other participants had a more difficult time being sure of the direct cause and effect of this contrast: "What was the cause and what was the symptom. I'm not really sure."

Judgment and the "good mother". The second theme to develop was the extreme judgment felt surrounding what it means to be a "good mother." Participants indicated they placed judgment on themselves through internally comparing themselves to other mothers and their own standards and expectations, as well as through perceived judgment from external sources such as through media and societal messages about mothering. Such perceived

judgments focused on the choices women were making regarding parenting and caretaking (i.e. breastfeeding, attachment parenting, buying organic) as well as the way the way women were coping with motherhood personally. This perceived judgment seemed to become a central issue in their struggle with postpartum depression.

Participants described a pressure to fill an idealized role of a graceful and put-together mother through the stories covered in magazines and the perception that it was unacceptable to be honest about one's unhappiness in motherhood: "you're inundated with the magazines that show, like, how she got her, you know, post-baby body back and all that stuff." These images became more visible and relevant to these mothers when they compared the media messages to their own experience and yet again, found a drastic contrast: "Every other mother you see is the happy one and the skinny one and the well-put together one." Participants said they struggled to find images and stories that depicted their own experience of motherhood and interpreted the lack of such stories to mean that they alone were not succeeding as mothers.

Participants internally judged themselves against the women around them as well. Women felt judged regarding their ability to perform childcare tasks well. They compared themselves against other mothers and attributed difficulties to their own shortcomings as mothers.

The breastfeeding thing was a big issue for me... we really struggled at the beginning. And...that was like, "this is what I should be doing... I should be doing it and I can't do it." And then you see the moms out feeding. You know, "What the hell, why can't I do this?"

The mothers also said they felt external judgment coming from their peers regarding the choices they were making as parents. One mother described her surprise at the judgment

surrounding *how* to mother:

I think I just thought as if, you know, whatever you did would be a good mother. It'd be easier. I was actually surprised about ...society's expectations and you know, if you breastfeed, if you don't breastfeed, if you let your child watch TV, if your child has a bottle after one, if they don't have bottle after one.

The women described feeling an enormous amount of confusion and pressure to conform to certain views of parenting that seemed to be changing constantly. As they sought to be a "good mother" by fulfilling the right tasks and roles they perceived their actions as being scrutinized by others and feared that if others knew how they felt they would be scrutinized more.

As the mothers described their experience with feelings of judgment and the tendency to compare themselves to other mothers, they also seemed to identify a perceived societal message that they should not be honest about their experiences. One participant commented on this judgment saying, "I think women are very judgmental, on ourselves, to each other... we want to project this image. 'I can do this, this is perfect, I am a strong woman.' So you don't admit these things [struggles]." These women reported feeling they were being given a message that it was not "okay" to discuss their struggles or that admitting to these struggles meant they were unsuccessful as mothers.

Perfection and success. The third salient theme under the umbrella of incongruence was the role these participants' drive to fill their role "perfectly" seemed to have on their experience of incongruence in motherhood. These women reported that they conceptualized their success as "good mothers" based on their ability to work hard to perfectly follow the "right" way to parent. However, because their status as a "good mother" depended on this perfection, any struggle with motherhood was interpreted as personal failure.

Many of the participants identified themselves as high achieving and hard working women, and recounted that upon realizing this inability to live up to the ideal role of a good mother they labeled themselves a failure. They reported blaming themselves for their struggle with motherhood and for the incongruence they experienced. “You don’t think that there could be another explanation for it. Clearly, this isn’t working, because I suck at it.”

This self-blame also seemed to grow out of a belief that the women could achieve success if they just worked harder at it, attempting to tackle a problem until they were nearly obsessed with it. For some women, the obsession became their struggles with breastfeeding, while for others it centered on a colicky child. The obsession with researching solutions and seeking guidance to was all in the hopes of “succeeding” as a mother. “Because you’re going to be like that good mother. You’re going to research it and fix it to death, yeah, until you fix it and become the mother of your expectations.”

For several of the participants, experience had told them that hard work would make them successful at anything. Thus, their expectations of motherhood had been that they would be successful at any task they needed to complete because they were a successful person. However, as they entered motherhood and later PPD and began to struggle with living up to their perceptions of a good mother, they labeled themselves as failures and blamed their experience on a personal shortcoming.

In sum, women’s experience of contrast seemed central to their experience of postpartum depression. Participants seemed to have impersonal and ambiguous expectations regarding motherhood before their pregnancies, but were still surprised and overwhelmed by their experience of motherhood. Participants reported their experience of PPD had been surprising because they had not expected their experience of being a mother to be unhappy. Participants

had expected they would be able to cope with motherhood, but found themselves overwhelmed by feelings judgment and pressure to be the perfect mother. In each of these areas, participants described feeling that their negative experiences were reflections on themselves as mothers. The feelings of judgment, inadequacy, and unhappiness seemed to lead participants to question themselves, and even their choice to become mothers: “I just kept thinking that over and over again. That, well, if I can’t do this and I’m not enjoying it, this was a terrible mistake.”

Changing the Meaning of Motherhood

The second purpose of this study was to understand how experiencing postpartum depression influenced or changed the meaning women ascribed to motherhood. It’s important to note that all of the women in this study were active members of a support group and some were seeking additional psychotherapy support to deal with their postpartum depression. We cannot know the impact that these additional support systems have had on participant’s perceptions or experiences. Women in the study didn’t necessarily discuss changes to what they believed it meant to be a good mother in the context of these support systems, however, we should keep in mind that it could have been through the support and validation received through these systems that women were able to challenge these expectations.

Mothers in the study noted that experiencing postpartum depression deeply impacted them. Women that had begun a process of healing took great pride in the strides they had made to overcome their struggle with PPD. For those women who where closer to moving past the experience of postpartum depression, their experience seemed to represented a challenge they overcame by discovering what was truly important to them about being mothers:

Would being a mother mean something different to me if I hadn’t experienced postpartum depression? I think, absolutely, for sure, and not in a good way. It was a

terrible experience and I wouldn't wish it on my worst enemy and I wouldn't go through it again for a million dollars. But, my life is so much better because of it... I feel like my priorities go sort of reordered in a really good way...Cause you know what, I'm alive and my family is intact and happy, you know. And, so everything else can, take a backseat.

Another participant described feeling more connected to her child after having experienced postpartum depression than she believed she would have been otherwise:

I'm actually proud of the mountain I just climbed and, you know, of my little stars and stripes on my shoulder. And I feel like my bond with my daughter is stronger than like the other mom who didn't go through this. Like, me and her, we went through a hell of a lot together.

Other participants described ways in which their experience with PPD had allowed them to help other mothers. These participants seemed to feel that even though their experience of postpartum depression had been devastating and painful, their process of healing had provided them with meaningful insight that could positively impact their family and the women around them.

Participants also indicated that their journey out of postpartum depression required addressing the judgment and contrast between expectations and reality. By working through experiences of postpartum depression, participants reported they re-examined what it meant to be a good mother and were then able to create a viable alternative to the "perfect mother" script. Mothers reported changing the meaning of motherhood in two ways; they set aside judgments from internal and external sources and made choices based on their needs and the individual needs of their children, and they incorporated the possibility of negative feelings into their definition of a good mother.

“Finding their own way” as mothers. Participants seemed to reach new conclusions about what it meant to be a good mother by engaging in a process of challenging previous perceptions and concluding they needed to “find their own way” as mothers. Regardless of women’s place in the process of overcoming postpartum depression, women identified that a focus on perfect motherhood and remaining silent to avoid judgment from others was problematic: “We won’t feel the need to do that anymore when people stop judging us for just making the choices that we want to make in our lives.” Women in the study described that at some point in their journey they began to take on an attitude of actively challenging the judgment associated with the presentation of “good mothers” in media and in societal messages about mothering. They instead, realized there were many ways to be a “good mother” because being a good mother meant making choices that met their own needs as well as the individual needs of their child: “Every baby’s different...there is no right and wrong.”

As participants sought help for their postpartum depression they seemed to become more adept at moving past perceptions of judgment and comparison against other mothers, and eventually began to change what it meant to be a good mother. For instance, some mothers began to see that their perceptions of the “right” way to complete mothering tasks actually didn’t suit their child. Some mothers described a demonstrable cognitive shift in their attitudes towards being a “good mother” when they came to realize they had the ability to build a unique and personal definition of how they would be a good mother. “It was weird. Finally, my mom convinced me that it was okay and there’s a difference between fussing and crying and I wasn’t a bad mom... And, I’d actually discovered what you said; different kids like different things.” Mothers were able to individualize a script for what they needed to do in order to best care for themselves and their children.

Several participants redefined a “good mother” as a “happy mother”, who cared for her child the way that best fit her and her child’s emotional and physical needs.

My New definition of a “good mother” is a happy mother. Period. End of story.

Because, everything trickles down from there. And that includes—are you breastfeeding or not, are you going back to work or not, and you know, all that other stuff that everybody judges about.... Because if you’re not happy, your child can’t be happy.

Essentially, participants seemed to become less dualistic in their evaluation of the information and messages they received. They no longer assigned the “good mother” label to only one choice. Mothers recognized that parenting involved many tasks and decisions, but that they needed to examine those decisions within the context of their own lives, and not strictly by the messages that media and society imposed on mothering.

Motherhood isn’t always “happy”. Although participants defined a “good mother” as a “happy mother”, they differentiated between being a “happy mother” and consistently being happy. While changing the meaning of motherhood meant making decisions that mothers could be happy with, it also meant challenging the perception that motherhood would always provide the women with overwhelming joy and happiness. When asked what messages they wished were more prevalent in society, one participant responded: “It’s okay if it sucks. Like, it’s okay if you feel awful because everyone says you’re not supposed to... It’s supposed to be the happiest time of your life and, clearly if it isn’t, you’re doing something wrong.” Another participant noted: “You can have post-partum depression and be a good mother, for sure.”

Participants seemed to shift their definition of a good mother to allow for the possibility of negative feelings. One participant described wanting reassurance from others that their feelings of unhappiness was not a reflection on them as mothers: “Someone saying, ‘Even

though you're feeling this way, you're not a bad mother. You won't always hate this child."... It would be nice to hear those things even if you don't believe it at first." By incorporating these messages into their definitions of a good mother, participants seemed to be working towards a goal of feeling secure in their abilities as mothers, even when feeling unhappy.

In sum, as participants sought help for their depression, they seemed to develop a new meaning of motherhood that empowered them to come to their own conclusions about being a "good mother". This new definition of a good mother also allowed them to retain that status, even when they were experiencing negative emotions. Essentially, the meaning of motherhood shifted. Whereas participants once believed being a "good mother" meant adhering to a narrowly defined script, through seeking support they seemed to come to the conclusion that "good" motherhood could take on many forms and included the possibility that women may experience negative emotions associated with mothering.

Desired Change

In order to address the third purpose of this study, addressing potential areas of change, women were asked to reflect on the societal messages they would change about motherhood. Participants' responses to this question reflected an understanding that while changes in messages and the way we talk about motherhood could have positive effects on mothers' experiences, women in the midst of postpartum depression have a difficult time separating their experience from being a reflection on their own worth as a mother. Participants recalled a reluctance to listen to others who were trying to help or persuade them that they needed help because they didn't feel their experiences were being simultaneously validated.

One mother, whose brother had tried to reach out to her, described her angry and defensive reaction when he suggested she didn't seem herself, and compared the reaction when a

friend and fellow mother reached out in a similar manner: “I mean I went *off* on him. How dare he? And, then a friend, not a relative, a friend who is a mom was like, “Something’s not right.” I was like, “Really?” So it was the difference of someone understanding.” Participants noted the importance of authenticity and of feeling understood when others try to reach out to women struggling with postpartum depression.

Ultimately, participants agreed that conversations regarding motherhood expectations and the pressure placed on mothers by the media needs to be a discussion that women engage in before giving birth. Participants advocated for conversations that would prepare mothers and fathers for the realities of parenthood and help them articulate their personal expectations for being parents. They recognized that articulating these expectations didn’t happen naturally in their own experience, and suggested different ways community entities could provide avenues for women to receive guidance and support.

The discussion led to two areas of potential change. The first, talking honestly about motherhood, captured the idea that the discussion of motherhood needs to change on several complex levels; from the way women communicate with each other about motherhood, to the way motherhood is presented in the media. The second, reaching out, focused on the active programs and initiatives that women felt would have been beneficial to their own experiences.

Talking honestly about motherhood. Participants expressed a desire for the conversation about motherhood to be more honest and transparent, at all levels of the conversation. They believed that honesty would transform, not just the way mothers felt about their individual experiences, but also the contrasting societal expectations and pressures for mothers to fit the “good mother” ideal. Mothers talked about the effects media stories about celebrity mothers had on their confidence as mothers, but also how messages from experts and

the larger health field added pressure to being the “perfect” mother.

I think that if the truth was more visible, how hard it is and how you might feel badly but it's not because you're a bad mom. I think the judgment on people would just be, these “Mommy Wars” would not exist. These things would dissolve when the truth is more obvious.

Participants perceived that many of these messages were presented dualistically, with a clear “right” and “wrong” approach to parenting fads and childcare and no attention given to the difficult realities of parenthood. Honesty about the experience and difficulty of motherhood, participants believed, would decrease the polarizing effects of these conversations and the perceived judgment women receive from them.

Participants also discussed honesty about motherhood in more relational terms. Drawing on interactions with other mothers and their personal experience of feeling judged, participants expressed a desire to see more honesty and vulnerability in the way they and other mothers shared their experiences. One participant noted:

I also think that when we get to a point, and this is, you know, idealized, I don't know if we'll ever get there — of letting women make choices that they want to make for their own lives, to make themselves happy, then there won't be so much pressure to put up this façade, like “I'm doing everything perfectly.”

Participants, however, noted that this façade is an unattainable expectation and leaves, “something missing from the story.” While still acknowledging the fear and judgment felt in their own experiences, participants suggested that without being more honest about the experience of motherhood and postpartum depression, the cycle of judgment would only continue to pass on to other mothers. Despite their own past perceptions of being judged,

participants felt it was important to be honest with others about the realities of their experience.

Reaching out. Participants felt strongly that talking about motherhood should incorporate honest representation of what motherhood was like. In order to make these ideological changes more feasible, the women in this study also expressed a desire for more support programs for all mothers, both before and after having children. Participants suggested parenting classes, mentorship programs, and preventative approaches that would not only provide support for mothers, but also facilitate honest discussion about motherhood expectations and experiences. Some of these suggestions grew out of opportunities mothers wished they had been given to seek help and support, but a few participants also expressed a desire to personally reach out to other mothers and support them in their experiences.

Discussion

This study was intended to expand on the results of prior research into women's experiences of postpartum depression, and specifically explored women's experiences of incongruence and changes made to the meaning of motherhood. Additionally, women in this study were invited to give feedback regarding changes they would like to see in the way we as a society address motherhood and postpartum depression. Participants talked about the changes and interventions they would like to see in the media, their relationships with other women, and their interactions with medical professionals. By expanding on previous findings, the results of this study further support suggestions that the contrast women experience between their expectations and reality of being a mother may be of central importance to understanding women's overall experience of postpartum depression and its possible causes (Beck, 2002; Knudson-Martin & Silverstein, 2009; Mauthner, 1999). These findings also pose some questions regarding the possible role that internal shifting of expectations and constructs of motherhood

play in women's attempt to reconcile their definition of a good mother with their experience of contrast.

Motherhood, Judgment, and Contrast

The present study found participants reported feeling social pressure to fulfill an idealized good mother role. Fulfilling the good mother role, which was constructed based in part on perceptions of judgment from other women, family members, and the larger social context, involved perfectly performing the childcare tasks in the "right" way and showing the world that they were coping with the new tasks perfectly. These findings align with one of Mauthner's (1998) previous studies on women's experience of incongruence with social constructs of motherhood, which found feelings of incongruence fall into three categories; infant care, the experience of depression after childbirth, and the expectation that they would be able to cope.

The relational aspect of perceived judgment is important in the description of women's experience with incongruence. Although participants' expectations of motherhood were ambiguous before childbirth, they reported feeling judged in active and present terms. Women reported feeling internal judgment relating to their struggle to reach perfection, but also reported experiencing external judgment as well, from other mothers, friends, and family. Mauthner (1999) noted that it was through these relationships that the social norms and expectations of mothers actually took on meaning and began to cause feelings of inadequacy. In other words, expectations were formed even while women were learning to be new mothers and became newly aware of the societal messages and judgments about how women should mother.

It is also interesting to note that the idea of perfection seemed to be of particular distress for the women in this study. Almost every participant in the group had pursued or completed graduate work beyond a four-year bachelors degree, suggesting that women in this study were of

a motivated and educated cohort. It's possible that the inability to cope with their new role of being a mother was a very new experience for them, and one that they discovered could not be overcome with hard work alone. This finding seems to speak to the incongruence between women's expectation that they would be able to cope with the difficulties of caring for an infant, but found themselves struggling to do so.

Whether seeking this perfection was a cause or symptom, or even a unique experience related to of postpartum depression is unclear, even to the women in the study who described this experience. It is reasonable to believe that many mothers who do not develop postpartum depression still feel intensely pressured to be a "perfect mother." The complete results of the present study, however, may suggest that seeking perfection became a central, nearly obsessive focus of the participating mothers who experienced postpartum depression, and may have contributed to a deepening of their depression. Once participants realized they were not able to achieve perfection in their role as a mother, they felt inadequate. For the women in this study, it was only through the challenging and reshaping of this perfect mother expectation that they were able to resolve their feelings of inadequacy as a mother.

Women in this study reported that in order to reconcile the contrast they experienced between expectations and their actual experience of being a mother, they began to change their personal definition of a good mother and the perfection needed to attain such a label. They redefined a good mother to be one who parented in such a way that met her needs and the needs of her child. This concept was captured through the theme "finding their own way" as mothers by changing their relationship to perceived judgment and their need to strive for "perfection." Mothers realized being a good mother didn't mean they had to attain perfection in parenting tasks, or in the way they coped with motherhood. Additionally, women changed their concept of

a good mother to allow for feelings of depression and difficulty coping.

Processes Unique to Postpartum Depression

The studies that support these findings on women's experience of incongruence rarely note whether this experience is one that all mothers go through (Beck, 2002, Kundson-Martin & Silerstein, 2007). However, there are findings to suggest that the experience of incongruence is present in every mother's experience, regardless of whether her struggle can be severe enough to warrant a diagnosis of postpartum depression (Choi, Henshaw, Baker, & Tree, 2005; Mauthner, 1999). The question that may be more helpful is: "how is this experience different in women who meet the requirements for postpartum depression?"

Choi, et al. (2005) studied mothers with varying experiences after childbirth, and while not all mothers experienced postpartum depression, they all described struggling with the degree of conflict between expectations of motherhood and their lived experience. For many of these women however, the process of resisting the ideology of perfect motherhood was not present. In response to feeling inadequate as mothers, the 24 participants in the study reportedly responded by working harder to reach perfection, rather than challenging and changing the personal meaning of what it meant to be a good mother. The findings of Choi, et al. might suggest that because only four of the 24 women in their study experienced postpartum depression, and the findings did not support a process of adjusting meanings or expectations, women who experience postpartum depression may go through a process of challenging social norms that women who do not experience postpartum depression may not have a reason or motivation to engage in.

Mauthner (1999) also touches on this question of processes unique to women with PPD. In contrast with what Choi, et al. (2005) might suggest, she suggests all mothers seek to resolve this conflict, but do so in different ways and with varying levels of success. Citing work by

Breen (1975) Mauthner proposes that women who do not experience depression after childbirth find it easier to accept their feelings regarding motherhood and discuss them in a responsive context (1999). Perhaps the findings in these studies suggest that the process of adjusting expectations is present in the experience of all mothers, but that the shift comes later and is then more pronounced for mothers who experience depression after childbirth. More study into this process as it relates to all mothers is needed in order to better understand the differences between depressed and non-depressed mothers.

Presence of this process in women with postpartum depression is supported in other studies as well. The change in women's definitions of a good mother represents a process of healing that Beck (2002) identifies as "making gains". Making gains includes processes in which women sought help from others and also adjusted unrealistic expectations women had for themselves as mothers. Beck's meta-analysis notes many of the findings from Berggren-Clive's 1998 study in describing this process further. Berggren-Clive found that adjusting expectations of themselves was a central part of women's process of rebuilding of the self. Furthermore, throughout the process of rebuilding self, women began to recognize and attend to their own emotional needs in meaningful ways (Berggren-Clive, 1998).

This potential process of healing differs slightly from what Knudson-Martin and Silverstein (2009) propose. In their discussion of the cyclic process of PPD and the paths through which women exit the cycle, they note that only through a supportive reaction from others can women break the cycle of PPD (Knudson-Martin & Silverstein, 2009). While the present study results are easily compatible with Knudson-Martin and Silverstein's model, women's experience of changing expectations and the meaning of motherhood seems to suggest a possible next step in this process. The results of this study suggest that after women are able to

reach out to others and feel validated, they must then address the conflict they feel between their expectations and experience of motherhood, which they do through challenging and adjusting what a good mother means to them. Evidenced by participant's involvement with a PPD support group and their ability to resolve some of these conflicts, seeking connection is likely a pivotal step in the road to recovery. Participants responses in this study may suggest that renegotiating what it means to be a mother is also an important step towards brining one's self out of despair and feelings of failure.

Study Limitations

Several limitations exist within this study. First, the choice of a phenomenological approach and the small sample size does not allow the results to be generalizable to a larger population of mothers and the report of findings is subject to the bias of the researcher. These results represent the opinions and experiences of a very small subset of women who have experienced postpartum depression and are currently seeking support and treatment. Additionally, the women who participated in this study represented a group of educated, married, and mostly Caucasian mothers, which is uncharacteristic of the entire population of mothers as a whole. The purpose of this study, however, was not to generalize findings to the larger population. Rather, the purpose of this study was to explore the complexities of the experience of postpartum depression as experienced by one group of women and attempt to describe these women's reported experiences in a concise manner.

Secondly, this study is limited by the purposive method of sampling used. All of the women in this study were members of the postpartum support group network through which participants were recruited. Furthermore, many participants were seeking additional individual psychotherapy and many indicated they were under the care of a medical doctor for their

postpartum depression. It is possible that participant's responses and the changes participants reported in the meaning they prescribed to motherhood were influenced and shaped by these interactions with helping professionals and other women. It is possible that through the experience of seeking help for PPD, women in this study had already been exposed to some of the ideas and questions presented in this study and have therefore already taken the time to develop responses and formulated opinions relating to these ideas.

Since many of the women in the study had been a part of the PPD support group for some time, their discussion and input may have been influenced by already having built a relationship with each other. This could be seen as a benefit to the study, because familiarity with each other could have contributed to more open and honest discussion. Conversely, this familiarity among some of the members could be viewed as a possible limitation to the study. Because the group was previously established, newer members of the group or members with dissenting viewpoints may have limited their participation in the discussion in order to avoid disagreement. While this study was not designed to reach a consensus amongst participants, self-silencing may have occurred by participants that were uncomfortable with voicing a difference of opinion.

Implications for Practice

Participants discussed desired changes to the discussion of motherhood that mirror suggestions from other studies. The need for expanded options for mothers that challenge traditional ideas of a good mother and encouraging frank discussion about the realities of mothering have been suggested implications of several studies discussed previously (Beck, 2002; Berggren-Clive, 1998; Choi, et al., 2005; Kundson-Martin & Silverstein, 2009). The desired changes reported by participants, as well as other results of this study have several implications for practitioners in the fields of mental health, medical, and community outreach.

Practitioners should provide opportunities for expectant mothers to articulate their expectation of motherhood and provide honest information regarding the realities of motherhood. Furthermore, practitioners must be aware of the varied judgments women experience from friends, family, themselves, and even the professional community. In essence, professionals should strive to promote an awareness of the messages society sends women about motherhood and what it means to be a good mother. By promoting flexibility within these motherhood ideals and providing validating feedback to women who speak out about their negative feelings regarding motherhood, more women may feel empowered to challenge these idealized expectations and instead, find their own way as a mother.

Directions for Further Research

More research is needed in order to further understand the role of relational and internal processes in the development of postpartum depression. Possible directions for research may include studying the experiences of adoptive mothers of infants. Studying the experiences of adoptive parents could help to distinguish the role of relational processes from the influence of hormonal and biological changes resulting from childbirth for women who experience depression after becoming a mother. Some studies have already begun to focus on the experiences of adoptive mothers against those of postpartum mothers, but more research is needed to determine the role of relational and internal processes in these populations (Mott, Schiller, Richards, O'Hara, & Stuart, 2011).

Additionally, further research should include the participation of mothers who did and did not experience postpartum depression, in order to determine if some of these processes take place for all mothers, or only mothers who develop PPD. Research is inconclusive as to whether all mothers experience some form of contrast between expectations and experience or shifting

definitions, or if these experiences are unique to women with PPD (Beck, 2002; Beggren-Clive, 1998; Choi, et al., 2005; Mauthner, 1999). Through expanding research that focuses on the social construction of motherhood to all mothers, researchers may be able to determine experiences universal to all mothers, or unique to certain mothers, and ultimately give greater breadth and depth to the scholarly knowledge of the experience of motherhood.

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Appendix A

Study Participants

Table 1	
<i>Participant Demographics</i>	
Characteristic	Number
Age	
31-35	3
36-41	4
Marital Status	
Married	7
Level of Education	
Bachelor's Degree or some graduate work	2
Master's or Professional Degree	3
Ph.D. or advanced graduate work	2
Work Status	
Currently employed part-time	2
Currently employed full-time	2
Not currently employed but intend to return to work full time	3
Time elapsed since giving birth	
0-6 months	2
6 months – 2 years	2
2-3 years	2
3 years or more	1
Did your experience with PPD occur after the birth of your first child?	
Yes	6
No, only after birth of second child	1
Duration of participation in support group	
1-6 weeks	3
6 weeks to 1 year	2
Longer than 1 year	2
Have you ever experienced depression or another mood disorder before?	
Yes, during my pregnancy	1
Yes, in the last 5 years	3
Yes, over 10 years ago	2
No	1

Appendix B

Letter to support group members upon confirmation of attendance:

Thank you for confirming your attendance on the night of the research study.

Attached you will find a copy of the study consent form and a list of questions that I will be using the night of the group interview.

Please review the consent form. Let me know if you have any questions regarding any part of the study. You may e-mail me or bring your questions with you the night of the study. I will have blank copies there for you to sign so there is no need to print it out.

The list of research questions are attached for your own information as well as to give you a chance to read them over before the group meets. Please review them briefly so you have an idea of what we will be talking about during the group interview. Again, I will bring fresh copies for you to use to follow along.

Your leader will be holding an abbreviated support group meeting during the first 30 minutes of the evening to check-in, should you need it. The following research study portion of the evening will last no longer than 90 minutes. If you find that you are no longer able to stay for the study after the initial 30-minute support group meeting please do not hesitate to excuse yourself. At no time are you under any obligation to complete participation in this study.

Let me know if you have any questions.
Thanks for your participation. See you then!

Elizabeth Leslie
Human Development
Virginia Tech
704-473-9830
ealeslie@vt.edu

Appendix C

Informed Consent for Participants in Research Projects Involving Human Subjects

The Experience of Postpartum Depression and the Perceived Societal Constructs of Motherhood

Elizabeth Leslie, Master's Student
Human Development

Purpose:

This research study seeks to better understand the relationship between women's experiences with postpartum depression and their experiences with society's messages about motherhood. By participating in this study, you will be helping to grow our knowledge of women's experiences with postpartum depression.

Procedures

You will be asked to complete a short questionnaire consisting of 13 questions. Then, I will conduct a focus group lasting no longer than 90 minutes. I will be using the same questions with which you were provided previously by your support group leader and have copies for you to follow along while I facilitate the group. The focus group session will be videotaped and audio recorded for research purposes. The recording of this session will be kept confidential and used only by myself, the researcher, and by my research team for research purposes only.

Risks

The risks of participating in this research study are similar to the risks associated with participating in a support group. Risks of participating in this study include the possibility of some emotional distress. To minimize this risk, you have already been provided with the research questions that will be asked.

Benefits

The benefits of participating in this research study are similar to benefits of participating in a support group. While there are no guaranteed benefits associated with participating in this study, benefits of participating in this study may include an increase in your personal understanding of your experiences with postpartum depression and the messages women receive from society, thus increasing your awareness of how these messages affect you and how you can respond to them. You may also experience greater support as you discuss your experiences alongside other women in the group.

Confidentiality

All information and video/audio recordings collected throughout the study process will remain confidential and will not be disclosed to individuals not directly involved in the study. Digital audio and video recording equipment will be used during the group interview process. These recordings will remain on the investigators hard drive under password protection and will not be shared with anyone else. All recordings will be securely deleted at the end of the study.

Questionnaire results and transcriptions of the group interview will be kept in similar electronic, data-secure fashion and will only be shared with the research team. The research

team will use a study ID number to identify your questionnaires and interview transcriptions.

Any hard copy forms, such as this consent form, will be kept in a closed envelope in a secure personal filing cabinet, apart from any study data.

Researchers are required to break confidentiality only in the case of reported child abuse or in the instance that the researcher believes the subject is a danger to themselves or others. Should disclosure of one of these situations occur during the study, the researcher is obligated to report the information to the proper authorities.

It is possible that the Institutional Review Board (IRB) may view this study's collected data for auditing purposes. The IRB is responsible for the oversight of the protection of human subjects involved in research.

Compensation:

There is no compensation for participating in this study.

Freedom to Withdraw

Participation in this study is completely voluntary. You may choose to leave the study at anytime throughout this process. If, for any reason, you feel you must decline to answer a question within the questionnaire or group interview you may do so. You are also under no obligation to answer any question within the questionnaire or group interview with which you feel uncomfortable answering for any reason.

Should you have any questions while filling out the questionnaire or at any time during the study process, please do not hesitate to ask me. I will be collecting your questionnaires and assigning them a study number to protect your anonymity. Please do not write your name on the questionnaires.

Questions and Comments

Should you have any questions regarding this study after the focus group concludes, I can be reached at the following e-mail address and cellular number. Below you will also find information should you wish to contact this study's faculty advisor or the Virginia Tech Institutional Review Board.

Elizabeth Leslie
Investigator
Master's Student
Dept. of Human Development
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I have read and understand the procedures and information listed above and I agree to participate in this study.

Printed Name

Signature

Date

Appendix D

Participant Questionnaire

Please answer the following questions. These responses will be used for descriptive purposes only. Remember, your answers and participation in this study are confidential and will never be shared with anyone outside the research team.

1. Age: _____
2. Marital Status: circle one
 - a. Single
 - b. Living with Partner
 - c. Engaged
 - d. Married
 - e. Separated/ Divorced
 - f. Widowed
3. Race/Ethnicity: circle one
 - a. Non-Hispanic White or Caucasian
 - b. Hispanic or Latino
 - c. African-American
 - d. African
 - e. Asian American
 - f. Asian
 - g. American Indian or Alaska Native
4. What is your religious affiliation? Circle one.
 - a. Protestant
 - b. Catholic
 - c. Other Christian Denomination
 - d. Jewish
 - e. Muslim
 - f. Hindu
 - g. Atheist or Agnostic
 - h. Prefer not to say
 - i. Other: _____
5. What is the highest level of education you have completed? Circle one.
 - a. Some high school
 - b. High school diploma or equivalent
 - c. Some college or currently in college
 - d. 2-year college degree (associates degree)
 - e. 4-year college degree (bachelors degree)
 - f. Some graduate work
 - g. Masters or professional degree
 - h. Advanced graduate work or Ph. D.
6. If you are currently a student, what is your student status?
 - a. I am not currently a student
 - b. Full-time student
 - c. Part-time student
7. Are you currently employed/ working?
 Yes.
Please circle one of the following:
 - a. I work full-time outside the home
 - b. I work part-time outside the home
 - c. I work from home
 No.
Please circle one of the following:
 - a. I plan to return to work full-time
 - b. I plan to return to work part-time
 - c. I worked before having children but have no plans to return to work
 - d. I have never worked outside the home.

Please continue to page 2 of the Participant Questionnaire

Participant Questionnaire continued

8. How long ago did you give birth? _____ Weeks/Months ago (circle one)
9. Was this your first biological child?
- Yes
- No this is child number _____
10. How many children do you have living at home? (Including children that may not biologically be yours) _____
11. Have you ever experienced depression or another mood disorder before?
- Yes, 10+ years ago
- Yes, 5+ years ago
- Yes, within the last 5 years
- Yes, during my last pregnancy
12. How long have you been involved in this PPD support group? _____
13. Have you received any psychotherapy treatment/support for your PPD? For instance from a therapist or counselor?
- Yes
- No

Appendix E

Focus Group Interview Questions

The Experience of Postpartum Depression and the Perceived Societal Constructs of Motherhood

*Elizabeth Leslie, Master's Student
Human Development*

1. How did you form your expectations about what it means to be a good mother before and during your pregnancy?
2. What were your experiences with the contrast between what you believed it meant to be a good mother and what you actually experienced?
 - a. How did the contrast affect you in relation to postpartum depression?
 - b. How did you respond to the contrast? How did it make you feel? How did you deal with it?
3. What does “motherhood” mean to you now that you have experienced motherhood and postpartum depression?
 - a. What does it mean to be a “good” mother now?
 - b. How did you come to a new meaning of “motherhood”?
 - c. Was it difficult to change the meaning?
 - d. Would being a mother mean something different to you if you hadn't experienced postpartum depression?
4. What information about the experiences of being a mother do you wish were more prevalent in media and society?
 - a. Are there alternative messages you wish were given to mothers specifically relating to experiencing postpartum depression?
5. Is the influence of societal messages concerning motherhood something you have talked or thought about before?
 - a. How might talking about and recognizing your perceptions of society's messages change the way you think about what it means to be a mother?