"You're not able to be yourself because people always expect you to be this ideal:" Women's Experiences with Contemporary Norms of Mothering, Help-Seeking, and Postpartum Emotional Difficulties

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University of Saskatchewan
Saskatoon

By
Chandra J. Decae

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ABSTRACT

The purpose of this study was to examine women's experiences with contemporary norms of mothering and help-seeking while living with postpartum emotional difficulties. Research showed that few women seek help for postpartum emotional difficulties (Fonseca et al., 2015; Henshaw et al., 2013). A review of the literature revealed many barriers to help-seeking including structural barriers, lack of knowledge of postpartum depression symptoms, stigma, shame, fear, and discomfort discussing symptoms (Corrigan & Watson, 2002; Edwards & Timmons, 2005; Fonseca et al., 2015; Foulkes, 2011; Leham, 2015; Sword et al., 2008; Thomas et al., 2014). In addition, contemporary norms of mothering were presented as a barrier to help-seeking (Leham, 2015; Thomas et al., 2014). However, neither of these two studies examined women's experiences with contemporary norms of mothering and how it related to help-seeking. Therefore, the research question for this study was: What are women's experiences with contemporary norms of mothering and help-seeking while experiencing postpartum emotional difficulties?

Four women who self-identified with experiencing depressive-like symptoms within a year after giving birth, who felt as though they were unable to seek help, and who felt impacted by contemporary norms of mothering participated in this study and shared rich narratives about their experiences. The data were analyzed using Interpretative Phenomenological Analysis (Smith, Flowers, & Larkin, 2009). Two super-ordinate themes emerged: *Stigma: A Barrier to Help-Seeking* with the constituent themes S*elf-Stigma, Unaware of Symptoms,* and *Perceived Stigma: Expectations from Others*; and, *Resilience: A Catalyst for Help-Seeking* with the constituent themes *Helping Oneself* and *Seeking Help from Friends, Family, and Professionals.* The themes describe the women's experiences of their shift in help-seeking. Initially, they were unable to seek help because of stigma; however, overtime the participants developed resilience within themselves which led to helping themselves and seeking help from others. This study provided valuable insight into four women's experiences with postpartum emotional difficulties, contemporary norms of mothering, and help-seeking. Considerations for mental health practitioners are discussed.

Key words: postpartum emotional difficulties, postpartum depression, help-seeking barriers, contemporary norms of mothering, stigma, resilience, qualitative research.

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DEDICATION

I dedicate this thesis to a few people who have inspired me, motivated me, and believed in me. First, I dedicate this thesis to the four women who allowed me to witness their reflections on their experiences with postpartum emotional difficulties, contemporary norms of mothering, and help-seeking. It was brave of you to step forward to participate in this research study knowing that you would be answering questions about experiences that are difficult to discuss. Your strength, resilience, and bravery inspire me. Thank you for sharing your experiences with me.

Second, I dedicate this thesis to my husband, Aaron, and my son, Henry. You have motivated me to complete my thesis, provided space for me when I needed the time to do my work, and loved me when I was experiencing stress related to thesis writing. Thank you for believing in me and supporting me through this process.

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CHAPTER ONE: INTRODUCTION

The postpartum period can be a difficult time for some mothers especially if they are experiencing postpartum emotional difficulties (Hall, 2009). Most commonly, postpartum emotional difficulties appear in the literature under the name postpartum depression (PPD). Postpartum depression also shows up in the literature through the terms perinatal depression (perinatal is "relating to the time, usually a number of weeks, immediately before and after birth" (Oxford University Press, 2017)) (Van Lieshout, Yang, Haber, & Ferro., 2017) and postnatal depression (Leahy-Warren, McCarthy, & Corcoran, 2011). Literature suggests that mothers can experience other postpartum issues such as postpartum anxiety (Wardrop & Popadiuk, 2013). As the majority of the literature uses PPD to describe postpartum difficulties, this introduction will provide statistics for PPD. However, the current study uses the term postpartum emotional difficulties as a way to encompass the myriad of postpartum difficulties that mothers can experience.

Postpartum depression (PPD) is a mental health condition that occurs after a mother gives birth (O'Reilly, Paterson, Bird, & Collins, 2008). It is classified in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) as a Major Depressive Disorder with peripartum onset, which "can be applied to the current or, if full criteria are not currently met for a major depressive episode, most recent episode of major depression if onset of mood symptoms occurs during pregnancy or in the four weeks following delivery" (American Psychological Association, 2013, p. 186). It is characterized by the following symptoms: (a) depressed mood, (b) loss of interest or pleasure, (c) excess weight gain or loss, (d) loss of appetite, (e) sleep disturbances, (f) agitation, (g) slowing of body movements, (h) fatigue, (i) decreased concentration or ability to think, (j) thoughts of suicide or death, (k) guilt, and (l) feelings of worthlessness (American Psychological Association, 2013, p. 161). Research has also described PPD to be characterized by hopelessness, anxiety, anger, low self-esteem, inability to cope, inability to confront day to day tasks, and lack of sex drive, which are not defined in the DSM-V (Cox & Holden, 2003; Letourneau et al., 2007; McCarthy & McMahon, 2008; O'Reilly et al., 2005; Ross et al., 2005). To be diagnosed with major depressive disorder with a peripartum onset, mothers must have had at least five symptoms in a two-week period; and, the symptoms (a) must cause significant interference with everyday life; (b) must not be the result of a substance or other medical issue; (c) must not be the result of other psychiatric disorders such as

schizophrenia; and (d) must not have occurred with a manic episode (American Psychological Association, 2013, p. 161).

As mentioned, the DSM-V requires symptoms to be present within the first four weeks postpartum to be classified as a Major Depressive Disorder with peripartum onset; however, literature suggests that symptoms can appear anytime within the first year after giving birth, not necessarily within the first four weeks postpartum (Banti et al., 2011; Cox, Bumna, Valenzuela, Joseph, Mitchell, & Woods, 2008; Gaynes et al., 2005). For example, Banti et al., (2011) examined the prevalence, incidence, and onset of perinatal depression in 1066 women following them from pregnancy through to one-year postpartum. Of the 1066 women, 142 women had a diagnosis of major or minor depression during the study. Out of the 1066 women who participated in the study, 1.2% of women stated their depressive symptoms began during pregnancy, 1.6% reported their symptoms began during the first four weeks postpartum, 0.5% of women reported symptoms began at six-months postpartum, 0.5% reported symptoms began at nine-months postpartum, and 1.6% of women reported symptoms began closer to twelve-months postpartum. Given these statistics, Banti et al. (2011) state that there is no evidence to conclude that perinatal depression peaks within the first-month postpartum. Similarly, Cox et al., (2008) described that women report symptoms of PPD beginning anytime during the first year postpartum. Gaynes et al., (2005) conducted a meta-analysis that showed women reporting an onset of PPD beginning anytime in the first year postpartum. Due to these findings, it is plausible to extend the onset of postpartum depression to include those symptoms that have begun anytime during the first year after giving birth.

Women who experience PPD not only experience the symptoms described in the diagnosis criteria for major depressive disorder with peripartum onset, but they also experience many emotional and mental difficulties such as feeling inadequate and incompetent as a mother (Wardrop & Popadiuk, 2013); disconnection from their former life (McKillop, 2009); and, loss of self (Vik & Hafting, 2012). Further, partners and children of women who experience PPD could be negatively affected (Beck, 1999). Beck (1999) discussed that women who experience PPD could risk a lack of affection with their children which could lead to later behavioural challenges in the child. Partners could risk becoming emotionally exhausted or experience their own depressive-like symptoms due to the extra demands of caring for someone with depression (O'Reilly et al., 2005). It is important for more women to seek help for postpartum emotional

difficulties to help themselves and to protect against the negative effects that could occur to the whole family.

Literature exploring postpartum emotional difficulties and PPD describes many benefits to seeking help. For example, Anderson (2013) described group therapies that focus on PPD by helping women through increasing access to social networks, decreasing isolation, and improving psychological health such as self-esteem. Van Lieshout et al. (2017) described that brief cognitive behavioural therapy is effective for reducing depressive symptoms for women who experience PPD. Even though seeking help has been shown to decrease depressive symptoms, research showed that few women seek help (Fonseca, Gorayeb & Canavarro, 2015). Fonseca et al. (2015) examined help-seeking in 656 women who were in the postpartum period. They found that out of 30.2% of women who screen positive for perinatal depression based on their scores on the Edinburgh Postnatal Depression Scale (EPDS), only 13.6% of women sought help for their depressive-like symptoms.

Literature also describes many barriers to help-seeking for women who experience postpartum emotional difficulties (Foulkes, 2011; Sword, Busser, Ganann, McMillan and Swinton, 2008; Thomas, Sharp, & Paxman, 2014). For example, common barriers to help-seeking include structural barriers, such as not being able to afford treatment and not having time for treatment (Fonseca et al., 2015); lack of knowledge about postpartum depression (Fonseca et al., 2015; Sword et al., 2008); stigma about PPD (Fonseca et al., 2015; Foulkes, 2011; Leham, 2015; Sword et al., 2008); and the presence of social norms of mothering (Leham, 2015; Thomas et al., 2014). Social norms refer to standards of behaviours that exist within a society about a specific group of people (McLeod, 2008). To emphasize norms that occur in current times, I use the term ‘contemporary norms of mothering’ throughout this thesis; however, when describing findings from other researchers, I use the term ‘social norms of mothering’ to align with their research terms. Contemporary norms of mothering refer to social depictions of what mothers ought or should be doing in contemporary times (Burchell, Rettie, & Patel, 2013, p.2). For example, Brown et al. (1997) described that mothers should be calm, patient, relaxed, caring, and able to handle the demands of her children. Thomas et al. (2014) described mothers’ stories of feeling as though they did not meet the standards of social norms of mothering because they were experiencing postpartum depression.

The emergence of contemporary norms of mothering presenting as a barrier to help-seeking for women who experience postpartum emotional difficulties piqued my interest. The two research studies that described social norms of mothering as a barrier to help-seeking did not further explore how social norms of mothering affect women and their help-seeking for PPD. I wondered what themes would emerge if women were asked specifically about their experiences with contemporary norms of mothering and how it affected their ability to seek help.

Personal Interest

My interest in this topic comes from my personal experience after the birth of my son. I self-identified with experiencing depressive-like symptoms in the year following my son's birth. However, I was afraid to seek help for fear of negative repercussions, such as being seen as a bad mom and fear of judgments. I felt my initial transition period to motherhood went smoothly as I had friends and family that helped me through the transition. In addition, my husband took three weeks off work to help around the house. He was helpful with housework, meals, and the emotional support that I needed while adjusting to taking care of my baby. I also gained friendship support through a prenatal course that introduced me to other mothers who had babies around the same time.

Approximately three or four months after my son was born, I noticed I was starting to struggle with the demands of taking care of him. I would share my struggles with my friends but noticed that others did not reciprocate by sharing their own struggles, which made me feel alone. Because it did not seem 'normal' to struggle with being a mom, I stopped talking about the struggles that I was experiencing. I began to isolate myself because I did not feel that I was able to express how I was feeling. I was afraid to reach out for help because I was afraid of judgments from others and, at the very worst, that I would be deemed unfit to parent because of experiencing depressive-like symptoms. In retrospect, I should have sought counselling, but I did not want to look like a 'bad mom' for feeling the way that I was. This made it hard for me to seek help. After a few months of struggling alone, I finally reached out to a friend of mine who shared that she experienced similar hardships after the birth of her children. She helped me not to feel so alone by telling me that other moms were having a hard time with the transition to motherhood. Hearing that others felt the same way helped me to feel normal again.

This experience helped me shape my research purpose. I felt motivated to research women's experiences with postpartum emotional difficulties. When I began researching this

topic, I soon learned that research examining PPD or other postpartum emotional difficulties is broad. Upon reading the article by Thomas et al. (2014), who as described above, stating that contemporary norms of mothering prevented women from seeking help, I realized that I was curious about this barrier and decided to take their study further, narrowing my focus. Thomas et al. (2014) examined an already existing chat room; therefore, they were unable to ask women specifically about their experiences with postpartum depression, help-seeking, and contemporary norms of mothering. This left me wondering what themes would emerge if women were asked specifically about their experiences.

My own experience with postpartum emotional difficulties following the birth of my child allowed me to have my own perspective on these difficulties leading to an increased amount of empathy for my participants. However, being close to the research topic, I realized that I could potentially carry assumptions about women's experiences with postpartum emotional difficulties, contemporary norms of mothering, and help-seeking. To bracket my assumptions and to ensure that I remained close to the data to view it from the participants' perspective, I continually engaged with the process of reflexivity by becoming aware of any preconceptions that I had in order to safeguard against biasing the data. I examined the data with the participants in mind and made sure to see the experience from the participant's perspectives and not my own. Throughout the analysis I noticed that themes were emerging that were surprising to me. Having themes that are surprising enhances the validity of a study (Ahern, 1999). Lastly, during the analysis process, I met with my supervisor to discuss the themes that emerged.

Professional Interest

I am professionally interested in this topic because of my interest for working in the counselling field. Through examining women's experiences with contemporary norms of mothering and how it affects help-seeking for postpartum emotional difficulties, I hoped to gain insight into these experiences which could help my counselling practice. I hoped to bring awareness to postpartum emotional difficulties in hopes that more women would feel safe to seek help for their experiences.

Purpose and Research Questions

The purpose of this research project was to examine women's experiences with contemporary norms of mothering and help-seeking while experiencing postpartum emotional difficulties. Four women who self-identified with experiencing depressive-like symptoms within

a year after giving birth and who felt as though they were unable to seek help for their difficulties participated in this study. They shared with me rich narratives about their experiences with postpartum emotional difficulties, contemporary norms of mothering, and help-seeking. As mentioned, contemporary norms of mothering had appeared in current literature as a barrier to seeking help for postpartum emotional difficulties; however, literature had not asked participants specifically about their experience with contemporary norms of mothering and help-seeking. Therefore, the research question for this study was: **What are women's experiences with contemporary norms of mothering and help-seeking while experiencing postpartum emotional difficulties?**

Definition of Key Terms

Contemporary norms of mothering: Based on definition for 'social norms', contemporary norms of mothering are social depictions of what mothers ought or should be doing in contemporary times.

Help-seeking barriers: Broadly defined as any factors that impeded the likelihood of a mother seeking help for her postpartum depression symptoms (Dennis & Chung-Lee, 2006).

Help-seeking facilitators: Broadly defined as any factors that influenced the likelihood of a mother seeking help for her postpartum depression symptoms (Dennis & Chung-Lee, 2006).

Postpartum depression: Also known as Major Depressive Disorder with peripartum onset; this means that depressive symptoms can start either during pregnancy or after giving birth (American Psychological Association, 2013). Other terms include perinatal depression (Van Lieshout et al., 2017) and postnatal depression (Leahy-Warren et al., 2011).

Postpartum emotional difficulties: The term the current study uses to describe emotional difficulties that women can experience after birthing a child.

Resilience: "The capacity to recover quickly from difficulties" (Oxford University Press, 2017, para. 1). Additionally, it is "the capacity to respond to pressures and tragedies quickly, adaptively, and effectively" (Graham, 2013, p. xxv). It allows an individual to cope with both daily stressors and uncommon stressors. In the context of this research, resilience is experienced by the participants through overcoming the self-stigma and perceived stigma they experienced, realizing that there are many definitions of a 'good mother' and coping with their postpartum emotional difficulties so they could continue to be the best moms that they could be.

Social Norms: Standards of behaviours that exist within a society about a specific group of people (McLeod, 2008). They are also described as "normative social influence with connotations of ought or should" and they describe patterns of group behavior (Burchell et al., 2013, p.2).

Social Support: Support that allows a person to feel that others understand their condition, practical support such as household chores (Cohen & Wills, 1985), support that promotes love and care, and support such as advice when asked (Anderson, 2013).

CHAPTER TWO: LITERATURE REVIEW

This chapter will begin with a discussion on postpartum emotional difficulties. It will show that research has focused predominantly on postpartum depression (PPD); therefore, most of the literature will refer to PPD when referring to postpartum emotional difficulties. This chapter describes risk factors of developing PPD, prevalence of PPD, experiences of PPD and other postpartum emotional difficulties, and the impact PPD has on families. Second, help-seeking and PPD will be discussed looking at barriers, stigma, and facilitators to help-seeking. Third, contemporary norms of mothering will be discussed. Lastly, this chapter will conclude with a summary and critique of the literature.

It is important to note that the current study used the term "postpartum emotional difficulties" as an umbrella term to describe the difficulties that women experience after birthing a child. I am using this term instead of "postpartum depression" for a couple of reasons: (a) the participant criteria for this study indicates that women self-identify with having experienced postpartum depression-like symptoms, and participants might not have received an official diagnosis; and, (b) literature suggests that women can experience a myriad of symptoms that may not fit under the diagnostic criteria of depression such as women who experience postpartum anxiety and antenatal anxiety. However, throughout the literature review, the terms postpartum emotional difficulties, postpartum depression, postnatal depression, antenatal depression, antenatal anxiety, and postpartum distress are used. When describing a study, I will refer to the same term that the original researcher used in order to remain consistent in the research.

Postpartum Emotional Difficulties

Research exploring postpartum emotional difficulties predominately focuses on postpartum depression. As stated in Chapter One, the *Diagnostic and Statistical Manual of Mental Disorder, Fifth Edition (*DSM-V) describes emotional difficulties that women face after birthing their child as a Major Depressive Disorder with a peripartum onset (American Psychological Association, 2013), once again confirming the primary focus on depression.

Research has shown that women can experience a myriad of emotional difficulties after birthing their child, and so this primary focus on depression might obscure the fact that a wider range of problems exists and might prevent proper treatment of women who do not fall under the threshold of depression. As the literature review will show, postpartum emotional difficulties are

also identified as postpartum anxiety, postpartum depression, postnatal depression, and antenatal depression. This section will begin by discussing prevalence and risk factors for developing PPD. It will then highlight a broader range of perspectives of women facing postpartum emotional difficulties and the impact that PPD has on the family.

Prevalence and Risk Factors for Developing Postpartum Depression

Across the United States, the prevalence for developing PPD is 1 in 8 (Centers for Disease Control and Prevention, 2016). The World Health Organization (2016) reports the global average for PPD is 13%, while developing countries report an average of 19.8%.

Canadian statistics have suggested lower than national and global rates. Lanes, Kuk and Tamim (2011) examined the prevalence rates of PPD and characteristics of developing PPD in Canadian women. Using both telephone and paper interviews, Lanes et al. (2011) interviewed 6,421 women. Participants, according to the Canadian Census of Population, were aged 15 years and older and had given birth to single babies between February 15, 2006 and May 15, 2006 in the Canadian provinces and between November 1, 2005 and February 1, 2006 in the Canadian territories. Postpartum depression symptomology (PPDS) was assessed using the Edinburgh Postnatal Depression Scale (EPDS). Major depression and minor/major depression were both examined; major depression was defined clinically as needing clinical treatment and including the symptoms of anxiety, sleep disorders, detachment from infant, irritability, and fatigue; minor/major depression was defined as a lesser form of major depression.

Lanes et al. (2011) claimed that Canadian women reported a national prevalence of 8.46% for minor/major PPD and 8.69% for major PPD. The prevalence rate in Saskatchewan was reported at 8.83% for minor/major PPDS and 6.87% for major PPDS. The Atlantic provinces, Prince Edward Island and New Brunswick, reported the lowest prevalence for both minor/major PPDS at 4.35% and major PPDS at 5.03; whereas the territories reported the highest prevalence at 14.05% for minor/major PPDS and 15.90% for major PPDS. Predictors for PPD were also examined: Lanes et al. (2011) suggested that lower household income, immigration status, younger age (15-19), prior diagnosis of depression, smoking, and higher stress levels during pregnancy were associated with experiencing PPDS.

Similar research has shown that previous mental health diagnoses, including antenatal depression and anxiety disorder, can increase the risk of developing PPD (Faisal-Cury & Menezes, 2012; Sutter-Dallay et al., 2004). Faisal-Cury and Menezes (2012) examined the

relationship between antenatal depression and postnatal depression through self-reports of 831 women. Results suggested that women who were diagnosed with antenatal depression were 2.4 times more likely to be diagnosed with postnatal depression than women who were not diagnosed with antenatal depression. In addition, Faisal-Cury and Menezes (2012) examined the link between socioeconomic factors and postnatal depression. Results indicated that history of miscarriage and three or more pregnancies are positively correlated with postnatal depression whereas regular contact with neighbours, years of education, and planned pregnancy were negatively correlated with postnatal depression. Given these results, the researchers suggested that history of miscarriage, the presence of more children, less contact with neighbours, lower education, and unplanned pregnancies leave women with a higher risk of developing postnatal depression.

Sutter-Dallay et al. (2004) studied the association between diagnosed anxiety disorders during pregnancy and postnatal depression. A study was conducted on 497 women assessing for anxiety disorders during pregnancy and then postnatal depression at six weeks post-delivery. Results from the study suggested that pregnant woman who were diagnosed with an anxiety disorder were 2.6 times more likely to score high on the postnatal EPDS (Sutter-Dalley et al., 2004).

Risk factors for postpartum depression can also include life stressors, prenatal vitamin use, and smoking during pregnancy (Dagher and Shenassa, 2012). Dagher and Shenassa (2012) examined the association between prenatal health behaviours and PPD with 662 women. Women were interviewed twice; once in the hospital within 24 hours of giving birth and once at home eight weeks after delivery. Results, using a hierarchical regression analysis, showed that women who smoked cigarettes at any time during their pregnancy scored 2.34 points higher on the EPDS than women who did not smoke. Women who consumed prenatal vitamins during the first trimester of pregnancy scored lower on the EPDS than women who did not take prenatal vitamins. Stresses related to parenting, including parenting responsibility, taking care of a fussy or colicky baby, and having a baby who is refusing to eat were associated with higher scores on the EPDS.

Broadening Perspectives of Postpartum Emotional Difficulties

The purpose of this section is to illuminate the broader perspectives of women facing postpartum emotional difficulties through discussing four studies. These four studies were

chosen for varying reasons. One reason being that postpartum anxiety does not exist in the DSM-V; therefore, women who report symptoms of postpartum anxiety are diagnosed with PPD (Wardrop & Popadiuk, 2013). I wanted to include research that provided examples of anxiety as an experience related to pregnancy and post-pregnancy. I chose Wardrop and Popadiuk (2013) and McKillop (2009) because they are both Canadian studies conducted within the last 10 years. Wardrop and Popadiuk (2013) challenged PPD as the dominant discourse in our society and added to the literature women's experiences with postpartum anxiety; McKillop (2009) explored women's lived experience and the meaning of living with antenatal depression. Vik and Hafting (2012), who examined women's experiences with loss during the postpartum period, was chosen to illuminate other experiences that women have during the postpartum period. Lastly, Hall (2009), who identified women's experiences and perceptions of postnatal depression, was chosen because it is commonly discussed in other literature which provides me with evidence that the findings are significant to postpartum depression literature.

Wardrop and Popadiuk (2013) challenged postpartum depression as the dominant discourse that describes postpartum emotional difficulties. While conducting quantitative research on PPD, Wardrop noted that many participants identified more experiences of postpartum anxiety than PPD. However, since postpartum anxiety is not a separate diagnosable term, women experiencing this type of distress are usually classified under an umbrella term of PPD (Wardrop & Popadiuk, 2013). Wardrop and Popadiuk (2013) aimed to challenge this dominant discourse and bring light to an understudied issue. Natalee Popadiuk, from Wardrop and Popadiuk (2013), stated the following:

> I became aware that this was not only an important psychological and medical issue, but also a social issue regarding the social construction of women's postpartum experiences and the silencing of anxiety experiences through the dominant discourse of postpartum depression (p. 5).

This statement is associated with the current research as it identifies the influence that society has on not only contemporary norms of mothering as will be described, but also the discourse that describes postpartum emotional difficulties.

Wardrop and Popadiuk (2013) used a Feminist Biographical Method to examine the experiences of postpartum anxiety in six Canadian first-time mothers. Participants were interviewed using a semi-structured narrative interview. The interviews were analyzed using a

hermeneutic lens. Five major themes emerged: (a) *experiences of anxiety*, (b) *expectations of a new mother*, (c) *issues of support*, (d) *societal scripts of motherhood*, and (e) *the transition*. Participants experienced panic attacks, excessive worry, heart racing, breathing difficulties, frustration, and anger. Although these experiences are all symptoms of postpartum depression, participants described feeling that their experiences more closely aligned with anxiety.

Three major findings surfaced in this study. First, the participants' shared experiences exposed the need to look more closely at postpartum experiences so that women can receive professional help tailored to their experiences. As stated, most postpartum distress is predominantly classified under postpartum depression; however, Wardrop and Popadiuk (2013) described that the women in their study related more to the term anxiety than depression. When anxiety is not recognized separately, many women go undiagnosed, and therefore may not receive the professional help that they need. Second, high expectations of mothering led to feelings of inadequacy and a lack of competency in participants' role as a mother. This further supports the purpose of the current study of linking social expectations or contemporary norms of mothering to postpartum emotional difficulties. Third, the findings of Wardrop and Popadiuk (2013) linked issues in women's health to the culture of western society. Wardrop and Popadiuk (2013) described that since Canadian culture is individualistic, new mothers take on this new role by themselves and learn how to be a mother through readings in books or online which further leads to isolation and loneliness. In other cultures that are more collective in nature, women learn how to be a mother through interacting with their culture and families (Wardrop & Popadiuk, 2013).

Research described that emotional difficulties could be experienced not only after birth, but also during pregnancy (McKillop, 2009). Recently McKillop (2009) explored the lived experience of antenatal depression in six women in Saskatoon who experienced mild to moderate levels of depression as scored on the EPDS. The participants were interviewed separately using a semi-structured interview guide. A hermeneutic phenomenological analysis revealed an overarching theme of *ambivalence* along with five sub-themes: (a) *disconnection vs new connection and/or reconnection*, (b) *loss of identity vs new identity*, (c) *fatigue and illness vs vitality and wellness*, (d) *anxiety and insecurity vs confidence and security*, and (e) *sadness and hopelessness vs job and expectation*. The findings of this study proclaim that women living with antenatal depression can have both positive and negative experiences at the same time, leading to

a sense of ambivalence. McKillop (2009) then questioned whether depression amongst pregnant women led to ambivalence about their pregnancy, or whether uncertainty about their future led to depression during pregnancy. However, McKillop (2009) was not trying to find a causal relationship between the two ideas; instead, she wanted to bring attention to the connection that ambivalence has to depression.

Similar to the current study, McKillop (2009) associated contemporary norms of mothering with depression during pregnancy.

> Though pregnancy and childbirth are not oppressive in themselves, the social context in which they take place have expectation and parameters that can limit women in their choices, thoughts and feelings around pregnancy and motherhood . . . and at most question the role that the social construction of pregnancy and motherhood play in depression during pregnancy (p. 95).

This association further illustrates the curiosity that the current researcher has in exploring women's experiences with contemporary norms of mothering and help-seeking while experiencing postpartum emotional difficulties.

When examining the different perspectives of postpartum emotional difficulties, it is important to challenge the dominant lens that describes these experiences. Vik and Hafting (2012) examined mothers' experiences with loss, postnatal depression and/or depressive symptoms through a sociological lens, in contrast to the majority of the literature which looks at postnatal depression through a medical lens. The researchers interviewed 15 women who experienced depressive symptoms using semi-structured interviews. The data from the interviews was analyzed using a phenomenological approach. Three main themes emerged from the study: (a) *loss of former identity*, (b) *loss of self-reliance*, and (c) *lack of capacity for self-care*.

The first theme of loss of their former selves described women grieving for their professional and/or social lives (Vik & Hafting, 2012). However, women were reluctant to express this loss due to social stigma. This theme identified women's feelings of worthlessness because they were no longer utilizing the professional skills that they had worked so hard to acquire. The theme of loss of their former selves described participants grieving over their changing bodies, finding their weight gain and stretch marks hard to accept. This theme also

described how participants felt as partners; because their relationships changed, they now had to figure out how to balance their roles as partners and as mothers.

Second, the theme of loss of self-reliance emerged, which described women who were no longer secure in their roles and abilities (Vik & Hafting, 2012). Women stated they faced new challenges that they did not feel confident in and were less able to control their emotions. Primiparous mothers (mothers with one child), felt a lack of confidence in their abilities (Vik & Hafting, 2012). Multiparous mothers (mothers with more than one child) felt insecure with their abilities because of the inconsistency of behaviour between children, despite their previous mothering experience (Vik & Hafting, 2012). Multiparous mothers also believed that it was difficult to balance the needs of a newborn while still tending to the needs of their older children. Both primiparous and multiparous mothers felt a lack of support from their partners but resisted asking for help due to feelings of insecurity. Additionally, loss of self-reliance was related to women believing that they had no control over their emotions. Some of the women discussed rapidly shifting from one extreme emotion to another; other women discussed feeling like their emotions came unexpectedly which caused distress.

Third, the theme of lack of capacity for self-care emerged as participants found maintaining basic hygiene challenging because of the demands of the newborn. Most women reported that catching up on sleep was more important to them than hygiene if they did have time to themselves (Vik & Hafting, 2012). Women in this study believed if their partner contributed more they would have time to tend to their personal needs for self-care. Some participants did not have time to recognize their need for self-care because they were occupied with hiding their experiences of PPD (Vik & Hafting, 2012).

PPD can affect women in all cultures. Hall (2009) used qualitative analysis and unstructured interviews to identify women's experiences and perceptions of postnatal depression in England. Ten women were invited to participate in the study; all 10 women scored higher than 12 on the EPDS, suggesting clinical depression; 5 women were primiparous, 5 were multiparous. The interviews were analyzed using Interpretative Phenomenological Analysis (IPA). Four general themes emerged from the data: (a) *difficulties in disclosure*, (b) *expectations*, (c) *beliefs around being a bad mum*, and (d) *attachment*.

The research described that women were reluctant to disclose their difficulties due to a fear of negative perceptions and a lack of understanding from others (Hall, 2009). Many

participants described that their expectations of mothering were not in alignment with their realities of mothering. They also believed that others perceived them to be 'bad mothers' due to their postnatal depressive experiences. The women reported that they did not feel an instant bond with their baby; some women discussed feeling as if their only purpose were to produce milk and perceived that their husbands had a greater bond than they did with the baby. Additional themes surfaced in this study that were not experienced by everyone but were significant enough to be discussed: (a) *a wish for help, (b) fear of harming their child, (c) feeling unjustified in being depressed, (d) self-doubt, feeling trapped,* and (e) *thoughts of suicide.*

As this section has shown, women can experience many different forms of postpartum emotional difficulties. Although the literature that explores postpartum depression and other emotional difficulties is more expansive than what is discussed, the literature selected reveals a sample of the array of difficulties that women face after the birth of their baby. The next section will describe how PPD can impact the family, followed by a section that describes help-seeking experiences for women who have experienced postpartum emotional difficulties.

Postpartum Emotional Difficulties: Impacts on the Family

As described in the previous section, PPD and other postpartum difficulties can affect mothers in many ways. PPD can also negatively affect the entire family (Beck, 2002; Beck, 1995). In a meta-analysis of 19 studies looking at the impact of PPD on the mother-child interaction, Beck (1995) concluded that PPD has a medium to large effect on the mother-child relationship. The meta-analysis revealed that women with PPD could lack affection and responsiveness toward their infant. This could cause later behavioural issues in children (Beck, 1999). Beck (1999) conducted a meta-analysis to examine the effect of maternal PPD on their children's behaviours later in life. The meta-analysis of 33 revealed a strong positive correlation between maternal postpartum depression and children's behaviour problems.

Partners and other caregivers can be negatively affected by a mother's PPD. The emotional toll that caring for someone with depression could impact the caregivers' own mental health (O'Reilly et al., 2005). Partners may take on more responsibilities with household chores or take care of other children. They may also have excessive worries about their loved one's PPD (O'Reilly et al., 2005).

A recent study, using IPA, examined men's experiences with their partner's PPD and the impact it had on their own fathering (Beestin, Hugh-Jones & Gough, 2014). The researchers

interviewed 14 fathers who had either a current or previous partner that experienced PPD. Eleven fathers discussed believing their fathering were affected by their partners' PPD; however, 3 fathers stated that they were not affected. Analysis was conducted with the participants who stated they were affected by the PPD. Results revealed an over-arching theme of *absence* with three sub-themes: (a) *fill the void*, (b) *thwarted fathering*, and (c) *investing in the father-child relationship*.

The theme of absence was expressed through fathers discussing believing their partners were physically, emotionally, and psychologically absent from parenting leaving the parenting responsibilities solely to the father (Beestin et al., 2014). Fathers also expressed that their roles of taking care of their partner changed the way they anticipated fathering. Some fathers discussed their fathering role was absent or thwarted because of the necessity of also taking care of their partner. Others discussed that the absence of their partner was experienced in their marriage. Some of the fathers stated that sole parenting along with the absence of their partner left them feeling lonely, isolated, and challenged. Contrary to the negative effects experienced, some of the fathers discussed the absence of their partner led them to strengthen their own relationship and connection with their children. Overall, this study suggests that a father's own well-being and fathering could be negatively impacted by having a partner experience PPD.

The literature selected reveals a sample of the impacts that a woman's postpartum emotional difficulties can have on the rest of the family. As mentioned, research also has yet to discuss how women's experience of contemporary norms of mothering relates to help-seeking. The following literature review will provide readers with a deeper understanding of women's experiences with seeking help for postpartum emotional difficulties.

Seeking Help while Experiencing Postpartum Emotional Difficulties

Postpartum emotional difficulties, left untreated, can have adverse effects on women's postpartum mental health leading to depression, anxiety, loss of interest, fatigue, and thoughts of suicide (American Psychological Association, 2013, p. 161). As mentioned, women's postpartum emotional difficulties can negatively affect the rest of the family (Beestin et al., 2014; O'Reilly et al., 2005). Therefore, it is important to research help-seeking in women with postpartum emotional difficulties so that more women can feel comfortable seeking help and which could thereby decrease the negative impacts of postpartum emotional difficulties. This section will begin by describing benefits to receiving support and statistics on the prevalence of

seeking help for women with postpartum emotional difficulties. It will conclude with literature describing reported barriers preventing help-seeking that women have experienced.

Benefits to Seeking Help

Research has shown that seeking help through professional, social, and pharmacological means can help women cope with postpartum emotional difficulties (Anderson, 2013; De Crescenzo, Perelli, Armando & Vicari, 2013; Van Lieshout et al., 2017). PPD-specific group therapies and non-PPD-specific group activities can benefit mothers who experience emotional difficulties by increasing access to social networks, decreasing isolation, and improving psychological health such as increasing self-esteem (Anderson, 2013). Brief group cognitive behavioural therapy has provided effective reduction in depressive symptoms for women with perinatal depression (Van Lieshout et al., 2017). Pharmacological treatment such as the use of selective serotonin reuptake inhibitors (SSRIs) has shown significant results in decreasing depressive symptoms for women with PPD (De Crescenzo et al., 2013). Research shows that women who do not receive appropriate levels of support throughout the first 12 weeks postpartum have a high risk of developing postpartum emotional difficulties (Leahy-Warren et al., 2011).

Anderson (2013) used semi-structured narrative interviews to explore women with PPD's experiences with support groups. The researcher interviewed 27 women; 23 women self-reported symptoms similar to PPD and 4 women did not disclose PPD-like symptoms. The women were clustered into three different support group types: a PPD support group, a mothers' group, and a working mothers' group. Interviews were analyzed using phenomenology.

The findings suggest that accessing support groups have left women feeling validated, understood, and accepted in their roles as a mother (Anderson, 2013). Participants from all three groups described improvements in their depressive symptoms and increases in the quality of care they provided to their children. However, there were markedly important differences between the groups. The PPD support group was described as feeling like the safest place for women to disclose PPD-like experiences. The participants described improvements to their self-esteem and self-worth, an increase in interactions with similar mothers, shared interactions including mutual aid support between participants, and an overall improvement to health. The mother's group provided opportunities for exchanges of information, social opportunities, and emotional support; however, the participants described feeling hesitant to open up about their experiences

with PPD. More participants described feeling safe to disclose their PPD-like symptoms within the working moms' group than within the mothers' group. The working moms' group was described as functioning primarily for exchanges of information and socialization for working moms.

Similarly, Van Lieshout et al. (2017) examined the efficacy of brief group cognitive behavioural therapy (CBT) interventions for women diagnosed with perinatal depression in Hamilton, Ontario. Using descriptive statistics, paired sample *t* tests, and Mann-Whitney tests, Van Lieshout et al. (2017) examined the impact of brief CBT interventions on depressive symptoms, mother-infant bonding, social support, relationship quality, and participant satisfaction. Overall, the brief CBT intervention significantly decreased depressive symptoms and improved interactions with social support, the quality of mother-child bonding, and relationship quality.

Pharmacological treatment, specifically using SSRIs, decreases PPD symptoms. De Crescenzo et al. (2013) conducted a systematic review of literature that examines the effectiveness of SSRIs with PPD. The researchers examined six randomized controlled clinical trials that included 595 participants. Results suggested that SSRI treatment is successful in decreasing PPD symptoms. Furthermore, the findings also suggested that SSRI treatment may be more effective than psychological treatment in patients who are in the acute phase of PPD.

Leahy-Warren et al. (2011) used a quantitative design to examine the relationship between receiving functional and social support and postnatal depression (PND) in 512 women who were at risk of developing PND. Functional support was described as informational, instrumental, emotional, and appraisal support; and, social support was described as support from social networks. Questionnaires were mailed to mothers and completed at 6 and 12 weeks postpartum. Data were analyzed using chi-square tests, a paired *t* test, and multivariate logistic regression models to assess the risk of PND at 6 and 12 weeks associated with the different levels of support.

A significant relationship between total functional social support and PND was found at 6 weeks. Mothers who received low- to mid-levels of support were found to be 6-12 times more likely to be at risk for PND when compared to mothers who received high levels of support. At 12 weeks postpartum, receiving emotional support was a significant predictor of PND risk levels. Mothers who received low to medium levels of emotional support had 5 to 8 times a higher risk

of developing PND. Looking at all four areas of functional support, mothers who received low levels of support were 8 times more likely to be at risk for PND. Mothers who received greater levels of functional and social support were less likely to be at risk of developing PND at 6 and 12 weeks. These findings further indicate the necessity of seeking help when experiencing postpartum emotional difficulties.

Prevalence of Seeking Help

As discussed, research has shown that receiving support is beneficial to those who experience postpartum emotional difficulties (Anderson, 2013; De Crescenzo et al., 2013; Van Lieshout et al., 2017). However, how many women seek either professional help or non-professional help when they are experiencing postpartum emotional difficulties? Two recent studies suggest that there are few women who seek help for postpartum emotional difficulties (Fonseca et al., 2015; Henshaw, Sabourin and Warning, 2013).

Henshaw et al. (2013) examined help-seeking, choice of treatment, and beliefs about mental illness in 36 women (combination of pregnant and postpartum) who were found to be at-risk for developing postpartum depression or anxiety. Data were collected using two separate interviews conducted six weeks apart. Help-seeking was examined through questionnaires that asked participants a series of yes or no questions about their help-seeking actions. Examples of questions are: (a) “Have you considered whether you might need treatment for depression/anxiety?” (b) “Did you attend an appointment with a mental health provider?” and, (c) “Did you attend a postpartum support group?” (Henshaw et al., 2013, p. 174). In addition, participants were asked to report their preference between mental health specialists, obstetricians, general practitioners, religious leaders, and other caregivers in their life.

Data analysis revealed that out of the 36 women in the study, 32% of women recognized that they might have depression or anxiety, and only 25% considered treatment. Out of the 32% of women who realized they had depression or anxiety, only 12% attended an appointment with a mental health professional, 6% attended a postpartum depression support group, and 5% called a postpartum depression phone support line. Surprisingly, 30% reached out to a friend or family member compared to 18% who reached out to their obstetric provider. Overall, Henshaw et al. (2013) suggested that roughly a third of their participants who experienced postpartum emotional difficulties sought help.

Similarly, Fonseca et al. (2015) examined help-seeking in women who were either pregnant or had had a baby in the last 12 months. In addition to help-seeking, Fonseca et al. (2015) examined sociodemographic, clinical predictors of help-seeking, and barriers to seeking professional help. Descriptive statistics were used to examine sociodemographic and clinical characteristics; chi-square tests and phi coefficients were used to examine the relationship between women's help-seeking behaviours. In total, 656 women participated in the study; 30.2% (*n*=198) were screened positive for perinatal depression using the EPDS, but 40.9% of women recognized that they might have postpartum emotional difficulties. Out of the women who were screened as positive for perinatal depression, only 13.6% (*n* = 27) sought professional help. Although few women sought professional help, 35.9% (*n* = 71) of the women who self-recognized emotional difficulties discussed their difficulties within their social networks. Interestingly, the sociodemographic data revealed that women who were married, highly educated, and had no history of psychological issues were found to be significantly less likely to seek help. Clinical predictors of seeking help included women who were single or divorced, older, less educated, and had a previous history of psychological issues.

Barriers to Seeking Help

The low prevalence reported of women seeking help for postpartum emotional difficulties leaves this researcher questioning what is preventing women from reaching out for professional help or support from their friends and families. Research suggests many barriers to help-seeking (Foulkes, 2011; Sword et al., 2008; Thomas et al., 2014). Results from Fonseca et al. (2015) described above suggest five barriers to seeking help. Structural barriers, such as not being able to afford treatment (23%; *n*=40) and no time to go for appointments (18.1%; *n*=31), were reported as the most common barriers. Lack of knowledge about peripartum depression was reported as the second most common barrier; the participants provided examples such as not knowing if their problems needed help (19.3%; *n*=33) and not knowing what treatment options to seek (16.4%; *n*=28). Lastly, fear of stigma (9.4%, *n*=16), shame (7.6%, *n*=13), and fear of others finding out (7.6%; *n*=13) were common barriers to seeking help (Fonseca et al., 2015).

Sword et al. (2008) conducted a qualitative descriptive study to examine women's experiences with accessing care after being diagnosed with PPD in a group of women who were a part of the Healthy Mothers, Healthy Babies program in Ontario, Canada. Eighteen women participated in the study. Telephone interviews were used to collect data. Through analysis, the

researchers found specific barriers that emerged as themes of influence on individual, social, and health care system levels.

On an individual level, themes of *normalization of symptoms, limited understanding, waiting for symptom improvement, discomfort discussing mental health concerns* and *fears* emerged. Participants spoke of disregarding their symptoms and thinking that it was normal to feel that way. One woman said, "I still don't think that what I was experiencing was postpartum depression. I think it was just an accumulation of not sleeping and being overwhelmed…" (Sword et al., 2008, p. 1165). Participants did not understand what they were experiencing and noted that they only thought they had to seek help if they had thoughts of harming themselves or their baby. Another woman spoke of feeling weak if she disclosed her symptoms, stating, "Well, for me it is just something very private because to me, it's just weakness..." (Sword et al., 2008, p. 1166).

On a social level, themes of *normalization of symptoms* and *limited understanding* were also present. Many participants spoke of believing family and friends, including their husbands, minimized and misunderstood their symptoms. They mentioned that their family and friends believed that these symptoms are normal to have after having a baby instead of being symptoms of mental health issues.

Lastly, on a health system level, themes of *normalization of symptoms, offering of unacceptable interventions,* and *disconnected care pathways* were present. Participants described health care providers normalizing their symptoms which prevented them from receiving the help that they needed. Participants also spoke of being offered pharmacological interventions but felt they were undesirable interventions because it affected their ability to take care of their baby. Within the health care system, participants reported feeling that there was a disconnect among health care professionals. One participant described being assessed as at-risk on the EPDS but stated that her family doctor was never given the diagnosis. Another participant described that she was not given any mental health assessment: "Like nobody was coming and assessing my depression, you know my psychological status or anything and I thought that was kind of odd" (Sword et al., 2008, p. 1168).

Similarly, Foulkes (2011) described barriers on the health care system level. Through exploring enablers and barriers to receiving help for women with postpartum mood disorders (PPMD) in a qualitative study using 10 women who were either diagnosed as having PPMD or

self-identified as experiencing many of the symptoms, Foulkes et al. (2011) described that women faced barriers with relation to both stigma and health care issues. Participants in the study believed their symptoms went unnoticed because no one discipline specifically focuses on maternal mental health. Even though participants noted coming into contact with health care providers (such as general practitioners, midwives, nurses), maternal mental health was not specifically monitored. Similar to Sword et al. (2008) participants spoke of believing that their health care providers lacked knowledge of PPMD. If PPMD were recognized, participants spoke of being offered only pharmacological interventions but feeling it was a "band-aid" or "quick fix" (Foulkes, 2011, p.455). Participants discussed that they wished to be offered a variety of intervention options.

Thomas et al. (2014) examined behavioural constructs connected with help-seeking in online stories from 36 mothers who self-identified with experiencing PPD. The constructs that were examined included *severity, social norms, barrier to help-seeking, facilitators to help-seeking,* and *self-efficacy*. Social norms were prevalent in 44% of the stories. Women in the study expressed believing they failed to meet the social norms of good mothering. A few of the women believed that people who were important to them suggested that they were failing to be a good mother; for example, one woman stated that her husband blamed her for not being a good mother; another woman said that society judges women for not meeting the social norms of good mothering by penalizing women instead of recognizing the mental illness. Many participants discussed feeling penalized for their PPD experiences which prevented them from seeking help for their experience.

Along with social norms of mothering, Thomas et al. (2014) provided insight into other barriers that prevent women with PPD from seeking help. The participants in the study discussed interpersonal relationships as barriers to help-seeking. Some participants spoke of feeling alone with their emotions through stating that none of their close friends had ever discussed similar experiences; other participants spoke of the need for privacy and not wanting to discuss their emotional difficulties. The participants narratives described feelings of shame and embarrassment which prevented help-seeking. The participants described being blinded by their difficulties and not realizing they needed help. Lastly, financial barriers, such as lack of insurance, prevented women from seeking help.

Stigma as a barrier. Stigma is discussed throughout research as a common barrier to help-seeking for women experiencing postpartum emotional difficulties (Barney, Griffiths, Jorm & Christensen, 2006; Edwards &Timmons, 2005; Leham, 2015). Stigma occurs when a person is faced with rejection or discrimination due to being perceived as different from mainstream society (Goffman, 1963 as cited in Edwards & Timmons, 2005). Stigma can take on at least three forms: (a) self-stigma, which are negative judgments towards themselves; (b) perceived stigma, which is perceived negative judgments from others; and, (c) public stigma, which occurs when society judges specific individuals or groups (Corrigan & Watson, 2002). This section will highlight three studies that capture the essence of women's experiences with self-stigma and perceived stigma in association with postpartum emotional difficulties. Leham (2015) described women's experiences with maternal mental health, stigma, and access to services; Edwards and Timmons (2005) discussed experiences of stigma as described by women who experience postnatal mental illness. Lastly, Barney et al. (2006) provided statistical data about participants' perceptions of self-stigma and perceived stigma amongst help-seeking for depression.

As mentioned, Leham (2015) examined lived experience of maternal mental health, stigma, and accessing services in six women who reside in Saskatoon. The experience of stigma was a repeated theme amongst the participants in this study. Additionally, Leham discovered the following themes in the women's narratives: *shame*, *vulnerability*, and *fear/anxiety*. The participants referred to shame in relation to the stigma perceived by friends, family, and society; and, self-perceived shame. Participants expressed that shame led to feelings of worthlessness as a mother. Shame created secrecy; participants felt that they were not able to share their experiences of maternal mental health which led to further feelings of shame, guilt, and isolation. Stigma from others reflected fear and misunderstanding of mental illness. One participant described that a family member had labelled maternal mental health with the word "crazy" further stigmatizing the illness. Stigma and shame were found in relation to taking medication; participants felt that they were afraid to disclose that they were taking any medication because of the stigma attached to it. Lastly, stigma led to difficulty in accessing support as participants recounted being fearful of disclosing their symptoms to friends, family, and physicians.

Edwards and Timmons (2005) focused on experiences of postnatal mental illness in six women who experienced postnatal mental illness without a past history of mental illness. Additionally, this study examined how the participants perceived themselves as mothers. Four

themes emerged in this study: *disclosure*, *access to services*, *feelings of being a bad mother*, and *label/diagnosis*. An underlying presence of stigma was found within all themes.

The participants described wanting to hide their experiences of postnatal illness from their friends or families. One women stated, ". . . I just didn't want people to know I had a mental illness, I would have preferred them to think I was in hospital for a physical illness, definitely" (Edward & Timmons, 2005, p. 475). Only when the participants begin healing from postnatal illness did they want to reveal their experiences. Many women found once they began to speak out about their postnatal illness, they found that other women had similar experiences which helped them to know that they were not alone.

Stigma was also described as delaying access to health care (Edward & Timmons, 2005). Participants discussed seeking help from multiple doctors before being diagnosed with postnatal mental illness. All of the participants described feeling that the diagnosis negatively reflected on themselves as a mother. Some participants feared facing negative consequences such as having their baby taken away. Some participants experienced stigma by perceiving that society would react negatively if they revealed their diagnosis. One woman felt hesitant about filling out a questionnaire that was required when leaving the country as it asked about previous mental health history. She feared that there would be negative consequences if she were upfront about the diagnosis. Even though many participants had negative experiences about being diagnosed, some participants felt a sense of relief once they were given the diagnosis because it validated and labelled what they were feeling.

Barney et al. (2006) examined the prevalence of help-seeking for depression through various sources of professionals, perceptions of stigma from others, and the role of stigma amongst help-seeking in 1312 residents in Australia. Data were collected through self-reported questionnaires. Participants were asked about their likelihood of accessing support from general practitioners (GP), counsellors, psychologists, psychiatrists, and complementary practitioners. The majority of the participants felt most likely to seek help from a GP (73%), counsellors (50%), psychologists (40%), psychiatrists (34%), and lastly complementary practitioners (37%).

Self-stigma was prevalent amongst the results; participants described feeling most embarrassed to seek help from a psychiatrist (44%), psychologist (38%), or counsellor (34%) whereas participants described feeling least embarrassed about seeking help from a GP (29%). Perceived stigma was examined as perceived condescension from the professionals and

perceived stigma from the community about seeing professionals. Analysis revealed that participants expected to receive condescension most likely from GPs (20%) and less likely from counsellors (16%). Similar findings occurred when participants were asked if they expected their professional caregiver would think of them as neurotic or unbalanced. The highest rating of stigma was expected from GPs (18%) and the lowest rating from counsellors (14%). Lastly, participants were asked about their perceptions of what others in the community would think of them seeing the professionals. Analysis revealed that participants felt the most perceived stigma for seeing a psychiatrist (46%), psychologist (39%), counsellor (32%), complementary practitioner (27%), and GP (21%).

Results showed that the presence of perceived stigma and self-stigma affected help-seeking. Even though this study did not look at help-seeking specifically for postpartum depression, it did provide statistics on the prevalence of self-stigma and perceived-stigma among help-seeking for depression.

Help-seeking and Resilience in Women with PPD

Resilience in women who experience postpartum emotional difficulties is an understudied phenomenon in the postpartum depression literature. Shaikh and Kauppi (2010) contributed to this area of research by examining resilience and coping strategies among women with PPD who live in rural locations with limited access to mental health resources. Purposive sampling was used to recruit 12 women who had either a psychiatric diagnosis of PPD or who self-identified with experienced PPD. Semi-structured interviews were used to gather the data which was analyzed using thematic analysis. Analysis revealed the following themes: *Meaning Making Strategies, Seeking Support, Nurturing Oneself, Advocacy Work*, and *Connecting with Nature.*

The theme of Seeking Support was comprised of three subthemes: *sharing motherhood responsibilities, accessing services,* and *connecting with other mothers.* The participants stated they sought help through partners, immediate family members, extended family members, and friends to assist with the day-to-day activities of mothering which would make room for the mothers to attend to self-care activities or seek professional help. The participants described accessing help through professional services such as health nurses and EAP counsellors. However, the participants noted many challenges to accessing services within a rural community including a lack of anonymity and privacy, and scarce resources. Some of the participants

described traveling to nearby cities to access professional services which relieved them from the privacy issue. The participants gained insight into the struggles that other moms faced through connecting with other moms and opening up about their own experiences. This normalized their struggles and allowed them to challenge their idea that they were a bad mom for feeling that way. Resilience was gained through feeling like their experience was normal and feeling like they were not alone (Shaikh and Kauppi, 2010).

As discussed, building resilience and coping with postpartum emotional difficulties can be gained through seeking help from professionals, family, and friends (Shaikh & Kauppi, 2010). Furthermore, positive help-seeking experiences have emerged in literature. After exploring constructs in an online PPD support group, Thomas et al. (2014) discussed women's descriptions of receiving support from female family members, support groups, and spiritual connections. Sword et al. (2008) examined help-seeking in women who were referred for probable PPD by a health nurse. They suggested that awareness of symptoms, encouragement to seek help, support from professionals, family and friends, validation of symptoms, timeliness of care, and follow-up by health-care professionals assisted women in initiating help-seeking.

Summary of Help-Seeking

Research shows there are many benefits to seeking help for postpartum emotional difficulties. Seeking help through postpartum depression-specific groups improves women's self-esteem, socialization, and psychological health (Anderson, 2013). Brief group CBT decreases depressive symptoms (Van Lieshout et al., 2017), and pharmacological methods such as the use of SSRIs significantly decrease depressive symptoms (De Crescenzo et al., 2013). Leahy-Warren et al. (2011) described that women who do not receive adequate support are at a higher risk of developing postpartum depression. Seeking support has many advantages to women who experience postpartum emotional difficulties; however, both Fonseca et al. (2015) and Henshaw et al. (2013) suggested that the majority of women who experience postpartum emotional difficulties do not seek help.

Women have described many barriers that could be preventing them from seeking help (Foulkes et al., 2014; Fonseca et al., 2015; Sword et al., 2015; Thomas et al., 2014). Fonseca et al. (2015) described barriers such as not being able to afford treatment and not having knowledge about postpartum depression. Sword et al. (2015) described barriers such as normalization of symptoms and the offering of unwanted interventions from health care providers. Foulkes et al.

(2014) described stigma being a barrier for many women. Thomas et al. (2014) described shame, embarrassment, and social norms of mothering preventing women from seeking help. Stigma as a barrier was expanded upon to describe women's experiences of stigma amongst help-seeking (Barney et al., 2006; Edwards and Timmons, 20015; Leham, 2015). Lastly, recent research on resiliency and coping strategies for PPD was discussed (Shaikh and Kauppi, 2010).

The next section will discuss literature pertaining to contemporary mothering to expand upon the experiences that contemporary women face once they become mothers. Contemporary norms of mothering will also be described.

Contemporary Mothering

Becoming a mother is a transition that could seem very easy to some women while relatively difficult for others. The transition to motherhood begins during pregnancy and ends once the mother feels confident in her role (Darvill, Skirton & Farrand, 2010). A new transition occurs when a woman shifts from being a mother of a single child to becoming a mother of multiple children (Aber, Weiss & Fawcett, 2013). Contemporary mothering is influenced by many factors including social media, friends, and families (Hall, 2009; Choi, Henshaw, Baker & Tree, 2005). The following section will describe literature that examined the transition to becoming a mother followed by the contemporary social constructed norms of mothering.

Transition to Motherhood

The transition to motherhood can be unique for each mother. The complexity of this transition is guided by many factors. Support from husbands, family, and friends as well as education about physical and mental changes during and after pregnancy can contribute to an easier transition for most mothers (Choi et al., 2005; Darvill et al., 2010). However, mothers whose expectations were different from what they experienced felt greater distress once the baby was born (Emmanuel, Creedy, St. John, & Brown, 2011). Unmet expectations about mothering led mothers to feel unprepared and overwhelmed in their new roles (Choi et al., 2005). Two studies will be discussed that examined women's experiences with the transition to motherhood (Choi et al., 2005; Darvill et al., 2010).

Darvill et al. (2010) used a comparative method to analyze semi-structured interviews of 13 women over the age of 16 who gave birth to their first child in the 15 weeks prior to the interview. The aim of the study was to examine women's experiences with the transition to becoming a mother. The overarching theme of *changes in the woman's self-concept* emerged

along with three sub-themes: *control, support,* and *forming a family*. First, women's experiences with control related to believing they had no control over their changing bodies or how they felt. For example, the women experienced perceived vulnerability to harm that could happen to their unborn fetus. Second, they experienced an increase in reliance on others for support. The women relied on knowledge about pregnancy and motherhood as they were first-time mothers, encouragement from partners because of feelings of insecurity, and normalization of emotions and changes to their body from other new mothers. Third, women's self-concept changed from being an individual or a couple to being a part of a family. In addition to the three themes identified, Darvill et al. (2010) found that women in their study began their transition to motherhood in early pregnancy. Many of the women experienced hardships during this transition especially if they did not have sufficient support.

Choi et al. (2005) interviewed 24 mothers to examine their experiences with the ideology of motherhood that is socially constructed in femininity during their transition to motherhood. Two themes were extracted from the data; they are *the realization of new motherhood* and *coping with new motherhood*. The researchers described that motherhood, for many of the women, was not what they expected. Many women reported they had to face the reality that motherhood was not how the media portrayed it, with examples such as motherhood being a happy experience and motherhood occurring naturally. Women described feeling inadequate and unprepared for the transition to motherhood because of the media portrayals. Similar to Darvill et al. (2010), many of the women in this study reported that support from family and friends who were also mothers was important during the transition period to cope with the tasks that are associated with being a new mother. Many women discussed that coping meant not only taking care of the baby but also taking care of household tasks. They discussed having mixed feelings about reaching out for support from others because they believed that by asking for help, they had to admit to feeling inadequate and give up their facade of being "supermom" (Choi et al., 2005).

Contemporary Norms of Mothering

Social norms are described as "normative social influence with connotations of *ought* or *should*" and they describe patterns of group behaviour (Burchell et al., 2013, p.2). Thus, contemporary norms of mothering are thought to be social depictions of what mothers *ought to be* or *should be* doing. Women are believed to be expected to comply with socially constructed

notions of mothering which take away from individualized ideas of the mothering and their role (Ambrosini & Stanghellini, 2012). Those who do not adhere to contemporary norms of mothering can be at risk of believing they are a failure which can lead to other depressive symptoms and eventually PPD (Ambrosini & Stranghellini, 2012; Kantrowitz-Gordon, 2013).

Kantrowitz-Gordon (2013) used discourse analysis to examine an online internet forum looking at the language and discourse that women used to describe their experiences with postpartum depression. The analysis revealed words used as judgments with participants comparing themselves to an "idealized mother." Participants' accounts described that an "idealized mother should love her baby, want to hold her, and attend to her needs at all times" (Kantrowitz-Gordon, 2013, p. 879). The participants who did not feel they fit into this definition of an idealized mother used words such as "bad mother," "failure," "guilt," "horrible," "evil," and "weak" (Kantrowitz-Gordon, 2013, p. 879). Participants reported feelings of shame and embarrassment for seeking help. One woman reported feeling embarrassed to see her OB/GYN because she thought she would be perceived as a hypochondriac; another woman reported shame in asking for support because she felt that people would tell her to just get over it already.

Brown, Small, and Lumley (1997) asked a group of women to explain what it meant to be a "good mother." They interviewed 53 women; 45 scored high on the Edinburg Postnatal Depression Scale (EPDS), indicating that they were experiencing PPD; 9 scored low, indicating that they were most likely not experiencing any depressive symptoms. The two groups of women did not differ on their depictions of what it takes to be a "good mother;" however, the two groups were not treated equally and did not have an equal number of participants in them which could skew the results of the study. Even though the study is almost 20 years old, it is still interesting to report the criteria that women felt would make a good mother in that time period. Participants reported that a "good mother" is caring (38%), patient (25%), calm and relaxed (11%), able to handle demands of children (7%), and in control of her temper (4%) (Brown et al., 1997, p. 190).

After examining postpartum anxiety in six Canadian first-time mothers, Wardrop and Popadiuk (2013), discussed two themes in particular that relate to contemporary norms of mothering. They are *Expectations of a New Mother* and *Societal Scripts of Motherhood*. Participants expressed that the following expectations contributed to postpartum anxiety. The reality of the amount of work that accompanies taking care of a baby was greater than what was expected. Some participants felt that they did not need to prepare for motherhood because they

expected mothering would come naturally. Participants who compared themselves to other mothers placed expectations on themselves; if they did not feel that they were living up to these expectations, they experienced a great amount of anxiety. Lastly, participants expected to feel an immediate bond with their baby; however, many participants stated that this bond did not appear instantly, but instead the lack of an instant bond created anxious feelings.

The theme of Societal Scripts of Motherhood described societal representations of mothering that participants felt affected their experiences with postpartum anxiety (Wardrop & Popadiuk, 2013). First, participants discussed the inability to relate to the representation of mothers in the media. Additionally, if postpartum distress was discussed in the media, participants felt the media portrayed these mothers in a negative light. Other media representations made mothering seem easy and less time consuming. Second, participants perceived that there was stigma attached to struggling. They described that they were not able to open up about their experiences with anxiety because they perceived it was not a norm of society to discuss the difficult side of mothering. Participants experienced a great deal of pressure to conform to the societal expectations of mothering described perceiving judgements if they did not conform. Gender roles are scripts of motherhood that participants believed was society-driven. Fathers were not expected to have the same preparation, skills, and knowledge of parenting as mothers were expected to have. Additionally, participants described that mothers were expected to complete more household tasks than fathers. Lastly, social class and ethnicity were factors that were influenced by society. If a mother was in a higher socioeconomic status, she was more likely to be able to afford help, better equipment, and resources. Immigrant mothers felt torn between conforming to Canadian norms of mothering and continuing with their norms from their native cultures. If they did seek help for their anxiety, immigrant mothers felt that there was a language barrier and could not get the help that they needed.

Most recently, a Master's thesis completed by Leham (2015) examined the lived experience of maternal mental illness, stigma, and accessing health care in six women who resided in Saskatoon. In relation to the current study, the women's narratives uncovered themes that included stigma and social norms of mothering. Stigma was previously discussed in the section on help-seeking; social norms of mothering will be discussed.

Leham's (2015) analysis revealed descriptions of social norms and expectations of motherhood that were present during experiences with maternal mental illness and stigma.

Participants explained feeling the pressure to reflect the socially acceptable picture of mothering that was present in the interactions with friends and family. The belief of not fitting in with this view left participants feeling judged and stigmatized and left them questioning their ability as a mother. Having a mental illness, and understanding that society has a negative view of mental illness, created a fear of being labelled and stigmatized socially. Thus, women believed they were not conforming to the social expectation of a happy mother.

Summary and Critique of the Literature

Literature exploring postpartum emotional difficulties reveals many terms used to describe the difficulties that women can experience pre- and post-birth. Postpartum depression, postpartum anxiety, antenatal anxiety, and postnatal depression are a few of the selected terms used to describe this phenomenon; however, major depressive disorder with a peripartum onset is the diagnostic term used by the DSM-V (American Psychological Association, 2013). Canadian research suggests a national average of 8.69% prevalence rate for PPD (Lanes et al., 2011) which is lower than the United States of 12.5% (Center for Disease Control and Prevention, 2016) and the global rate of 13% (World Health Organization, 2016).

There are many factors that place women at risk for developing PPD. Previous mental health diagnosis, previous miscarriages, isolation, and the presence of more children increase the risk for developing PPD (Faisal-Cury & Menezes, 2012) as well as experiencing anxiety during depression (Sutter-Dallay, 2004). Smoking, prenatal vitamin use, and parental stress can also contribute to the development of PPD (Dagher & Shenassa, 2012).

Research described that the presence of PPD in the mother can negatively impact the mother-child relationship (Beck, 1995), the mother-father relationship, and the father-child relationship (Beestin et al., 2014). Fathers have described believing their partners were physically, emotionally, and psychologically absent, not only in their relationship but also in their own parenting, leaving the fathers to fill the void and contribute more to parenting. Some fathers discussed feeling as though they were not able to connect as much with their children as they had to take care of their partner while other fathers discussed connecting more with their children because of the absence of their partner (Beestin et al., 2014). Given the impact that PPD can have on the mother, father, and children it is important for women to seek help to recover from PPD.

There are many benefits to seeking help for PPD. Support groups, PPD-specific groups, and pharmacological interventions have decreased depressive symptoms and increased social interactions, mother-child interactions, relationship quality, and greater overall health (Anderson, 2013; De Crescenzo et al., 2013; Van Lieshout et al., 2017). However, research has suggested that few women seek help for their postpartum emotional difficulties (Henshaw et al., 2013). There are many barriers that prevent women from seeking help such as not being able to afford treatment and not having time for treatment (Fonseca et al., 2015). Many women described feeling shame, stigma, and fear about disclosing their PPD-like symptoms (Fonseca et al., 2015; Sword et al., 2008; Foulkes, 2011; Thomas et al., 2014; Leham, 2015). Lastly, being unaware of symptoms, isolation, and the presence of contemporary norms of mothering have impacted women's help-seeking (Thomas et al., 2014).

The presence of contemporary norms of mothering depicting the definition of a "good mother" has been present in society for some time. In 1997, Brown et al. (1997) published an article that describes women's definitions of the qualities of a "good mother." The words used were "caring," "patient," "calm," and "in control of her temper" (Brown et al., 1997). Research conducted 16 years later used similar terminology to describe women's definitions of a "good mother." The participants described believing they were a failure or a bad mother if they did not fit the mould of a "good mother." The presence of contemporary norms of mothering can be influenced by the media, interactions with society (Wardrop & Popadiuk, 2013), and interactions with friends and family (Leham, 2015; Thomas et al., 2014).

It is interesting to research contemporary norms of mothering and the descriptions of what participants in these studies felt would make a "good mother." Is it possible for a human being to always be patient, calm, relaxed, in control of her temper, and always wanting to hold her baby as the research of Brown et al. (1997) depicts? I questioned these standards and wondered how women who experienced postpartum emotional difficulties experienced these contemporary norms of the "good mother." I speculated that it is not possible for anyone to uphold these standards in any area of life, yet many mothers feel that if they are not this idealized standard, then they are not a good mother.

As discussed, Thomas et al. (2014) explored important constructs that impede help-seeking for many women who experience postpartum emotional difficulties including social norms of mothering. However, Thomas et al. (2014) examined stories that were made available

on an internet platform for women with PPD. Given that the information was already discussed and the participants were not directly asked about help-seeking, I wondered what themes or insights would emerge if participants were asked directly about contemporary norms of mothering and help-seeking? I wanted to take this study a step further and explore these constructs deeper and wondered what themes would emerge if I could ask participants directly about their experiences with contemporary norms of mothering and help-seeking while living with postpartum emotional difficulties; and, what insights could be shared that could potentially impact other women's help-seeking in a positive way?

Similarly, Leham (2015) described social norms of mothering being present in women's descriptions of accessing services for maternal mental health. However, Leham's participant pool examined women who were already accessing services. I wonder about the presence of contemporary norms of mothering for women who did not feel they could access services and for women who may not have a diagnosis related to maternal mental health. What additional barriers to help-seeking are present when women feel influenced by contemporary norms of mothering?

Missing in the current literature was a thorough examination of women's experiences with contemporary norms of mothering and help-seeking while living with postpartum emotional difficulties. Therefore, the purpose of this research was to explore this phenomenon further using the following research question: **What are women's experiences with contemporary norms of mothering and help-seeking while experiencing postpartum emotional difficulties?**

CHAPTER THREE: METHODOLOGY

The following chapter will begin with a description of the methodology used, including qualitative inquiry, social constructionist theory, and interpretative phenomenological analysis (IPA) to explore women's experiences with contemporary norms of mothering and help-seeking while experiencing postpartum emotional difficulties. Next, the methods used to examine this phenomenon will be discussed, including participant selection, in-depth semi-structured interviews and data analysis. This chapter will conclude with information detailing trustworthiness of the research and pertinent ethical considerations.

Qualitative Inquiry

Researchers use qualitative inquiry to explore participants' worlds and uncover rich meaning arising from their experiences (Van den Hoonaard, 2012). According to Merriam (2002), "The key to understanding qualitative research lies with the idea that meaning is socially constructed by individuals in interaction with their world" (p. 3). Van den Hoonaard (2012) believes that this type of understanding is common knowledge; however, the patterns that emerge go unnoticed until they are brought to awareness.

Qualitative inquiry can be described by two concepts: *sympathetic understanding* and *definition of the situation* (Van den Hoonaard, 2012). Max Weber (1864-1920) described qualitative research as taking an empathetic understanding of participants' experiences. In other words, in order to understand participants' experiences, the researcher needs to view it from the participants' view (Van den Hoonaard, 2012). Van den Hoonaard (2012) described taking a sympathetic understanding approach has helped her interpret her data more accurately to the participants' experience. W. I. Thomas (1863-1947) described the second concept, *definition of the situation* (Van den Hoonaard, 2012). The meaning of this concept relies on the definition that researchers use to describe a situation. If an experience is defined a certain way, then that definition will hold true in all experiences (Thomas, 1937 as cited in Van den Hoonaard, 2012). Qualitative researchers are also particularly interested in shared experiences between participants (Van den Hoonaard, 2012).

According to Merriam (2002), there are four key components to qualitative research. The first component states that researchers aim to uncover the participants' individual meaning behind their own experiences. Second, data collection and data analysis are done solely by the

researcher. Third, researchers inductively derive themes, concepts or theories from the data. Fourth, the findings are thoroughly described through writing.

The purpose of the current study was to examine women's experiences with contemporary norms of mothering and help-seeking while experiencing postpartum emotional difficulties. Qualitative inquiry was chosen for an in-depth understanding of this experience and to uncover the meaning that each participant made from their experience.

Social Constructivism

The social constructivist paradigm was used for this research project because it focuses on the subjective experiences of participants to determine their "truths" (Hays & Singh, 2012). As noted in Hays and Singh (2012), social constructivists first construct truth by examining the interactions between people, then reflecting on those interactions to examine individual truths. A quote from Evelyn Nakano Glenn adds to the merit of using this paradigm:

> As Third World women, women of color, lesbians, and working-class women began to challenge dominant European and American conceptions of womanhood, and to insist that differences among women were as important as commonalities, they have brought alternative constructions of mothering into spotlight. The existence of such historical and social variation confirms that mothering, like other relationships and institutions, is socially constructed… (Glenn, 1994, p.3).

This quote sheds light on the variations of mothering that exist in society and the challenges being brought to bear on the historical and dominant discourse on mothering. Women are bringing their differences forward to construct a new contemporary view that encompasses all variations of mothering.

Social constructivist paradigm posits that individuals develop their sense of self based on their interactions with others (Eatough & Smith, 2008). Knowledge is rooted in the historical and cultural assumptions of the current time and is developed through interactions and conversations between people (Burr, 2003). How we view our "truths" is through interacting with the current culturally accepted ideas of our time (Burr, 2003). Considering that the current study examines women's experiences with contemporary norms of mothering and help-seeking while experiencing postpartum emotional difficulties with a social constructivist viewpoint, I postulate that contemporary norms of mothering are constructed through individual's interactions with the world, discussions with other mothers and culturally accepted ideas of mothering. My aim was to

understand the participants' individual views of how they constructed their truths along with the struggles that have surrounding this. The next section will describe the methodology used for this study, interpretative phenomenological analysis.

Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) was used to examine women's experiences with contemporary norms of mothering and help-seeking while living with postpartum emotional difficulties. It was chosen as a methodology because it examines the lived experiences of a particular person in a particular place and time (Shinebourne, 2011; Smith et al., 2009). Research using IPA strives to understand and interpret what the world is like from the participant's perspective (Shinebourne, 2011; Smith et al., 2009). Analysis is guided by the social and historical influences of that specific time, directing focus on the researcher's interpretation of the participant's meaning of the experience (Shinebourne, 2011). Smith and Osbourne (2003) describe IPA as using a 'double hermeneutic' approach. It examines how a participant perceives an experience, and how the researcher makes sense of the participant's perception of the experience (Smith & Osbourne, 2003).

IPA was first developed in the early 1990s, deriving ideas from phenomenology, hermeneutics, and idiography (Shinebourne, 2011). It provides researchers with guidance to examine subjective experiences and the meaning that participants give to their experience (Shinebourne, 2011). Along with the three theoretical approaches described above, IPA is connected to social and cognitive psychology as IPA is focused on the mental processes of the participants, such as their thoughts, perceptions and sense-making (Smith, 2004; Smith & Osbourne, 2003). The following sections will describe the theoretical underpinnings of IPA: phenomenology, hermeneutics, and idiography.

Phenomenology

A significant component of phenomenological research is that it provides descriptive, thorough, and detailed accounts of lived experiences (Smith et al., 2009). It focuses on subjective experiences and the meaning or essence of the experience (Merriam, 2002). Phenomenological research is influenced by four main philosophers: Husserl, Heidegger, Merleau-Ponty and Sartre (Smith et al., 2009). The following will describe the contributions that these four philosophers had in influencing phenomenological research.

Husserl was a philosopher in the early 1900s. He argued that experience should be examined through a means of reflecting on the personal perceptions of that experience (Smith et al., 2009). Each experience should be examined in a way that is reflective of the perceptions of each individual involved. Although these reflections may be personal to the individual, they need to acknowledge that this experience is also reflective of how it relates to the experience of others in the world. Husserl's main contribution to IPA is the idea of reflecting on experience (Smith et al., 2009). Husserl emphasized the need to 'bracket' or set aside the surface experience to immerse ourselves into our consciousness to focus and reflect on our perception of that experience (Smith et al., 2009).

Heidegger was a student of Husserl. Whereas Husserl was interested in the individual perceptions of experience, Heidegger was more interested in understanding the person within that experience (Smith et al., 2009). A second key aspect of Heidegger's work was the introduction of the word *intersubjectivity* which "refers to the shared, overlapping and relational nature of our engagement in the world" (Smith et al., 2009, p. 17). Heidegger influenced the ideas that our perception of experience should always be understood in relation to the world, and that interpretation needs to reflect on how individuals make meaning of experiences (Smith et al., 2009).

Merleau-Ponty is similar to Husserl and Heidegger in that he was focused on examining ourselves in relation to others (Smith et al., 2009). Whereas Heidegger was interested in examining relationships between the experienced and the world, Merleau-Ponty was interested in the "embodied nature of our relationship to that world and how that led to the primacy of our own individual situated perspective on the world" (Smith et al., 2009, p. 18). He believed that our view of self is not one that is involved and consumed by the world but instead to be engaged and working with the world. Merleau-Ponty described that one can provide empathy for another individual, but can never fully understand another's experience, because that experience belongs to that person. His contribution to IPA is that "the lived experience of being a body-in-the-world can never be entirely captured or absorbed, but equally, must not be ignored or overlooked" (Smith et al., 2009, p. 19).

Lastly, Sartre, who is an existential phenomenologist, introduced the term *nothingness* to phenomenological research (Smith et al., 2009). Nothingness means that "things that are absent are as important as those that are present in defining who we are and how we see the world"

(Smith et al., 2009, p. 19). For IPA, Sartre strongly influenced the idea that relationships that are absent are just as important as relationships that are present. He also emphasized that the sense of self is always developing, that individuals are always free in their choices, and that they have to take responsibility for their actions (Smith et al., 2009).

For IPA, phenomenology has influenced the need to interpret individual understandings of how individuals relate to, experience and make meaning of the world (Smith et al., 2009).

Hermeneutics

Hermeneutics is the "theory of interpretation" (Smith et al., 2009, p. 21). It is particularly interested in the following questions: How and by what means is text interpreted? Can interpreters accurately represent the original voice of text? And to what extent are the original text and the interpreted text similar or different? Hermeneutics was historically used to interpret biblical passages, and later became a philosophical theory that guided general interpretation (Shinebourne, 2011). Hermeneutics is influenced by three theorists: Schleiermacher, Heidegger and Gadamer.

Schleiermacher was interested in the interpretations that a writer can make about a text (Smith et al., 2009). He thought that the interpreter was able to offer a perspective on the experience that might not have been thought of by the original creator of the text. This overview of an additional perspective was particularly adopted by IPA researchers who thought that this way of viewing information was beneficial to research (Smith et al., 2009).

Heidegger, who is known for his contributions to phenomenology, has also contributed to the area of hermeneutics. In regards to interpretation, Heidegger argued that past experiences are always present when interpreting an object or experience. However, instead of our past experiences influencing the current experience, Heidegger argued that current interpretations can help one to make sense of past experiences (Smith et al., 2009). This is influential in IPA in that it challenges the phenomenological role of 'bracketing' (Smith et al., 2009)

Gadamer's philosophy of hermeneutics takes into consideration both Heidegger's and Schleiermacher's points of view. He agrees with Heidegger in that our interpretations can allow us to make sense of past experiences which later influences our interpretation (Smith et al., 2009). However, Gadamer challenges Schleiermacher's idea that the interpreter can better understand the experience than the person who experienced it. Instead, Gadamer argued that

understanding the person who was in the experience is most important; understanding the interpreter's meaning is second (Smith et al., 2009).

Lastly, the hermeneutic circle influences the analysis portion of IPA (Smith et al., 2009, p. 28). To thoroughly interpret text, the researcher must first understand all text as a whole, then understand and look at individual pieces of the text, and then use that understanding to again look at the text as a whole. IPA adopts this method of interpreting data to allow the researcher to visit the data with different lenses, at separate points in time, to pull out interpretations while considering the data as a whole and the data as individual pieces (Smith et al., 2009).

Idiography

Idiography examines 'the particular' (Smith et al., 2009, p. 29). It is interested in the particular person who is experiencing the phenomenon. Idiography examines the particular in two steps. The first step is to conduct a deep and detailed analysis of the particular person. The second step is to examine how that particular person made sense of that particular phenomenon in a particular setting (Smith et al., 2009). Idiography is also interested in adopting the method of a single case study; however, it is more interested in combining the analyses of multiple single cases to create one multi-faceted analysis (Smith et al., 2009). Analysis starts as a single case study with individual cases that are later considered as a whole for more general analysis (Shinebourne, 2011).

IPA methodology is congruent with the purpose of the current study because of the methodological focus on individual experiences with the world (Smith et al., 2009). The focus of the current study was to examine women's experiences with postpartum emotional difficulties (idiography), their experiences with contemporary norms of mothering and help-seeking (phenomenology) and how these women perceive, manage and make meaning of this experience (hermeneutics). This methodology was chosen because I wanted to gain an insider's perspective on this experience (Smith & Osbourne, 2003).

Participant Recruitment

Participants for this study were recruited through purposive sampling which bases selection of participants on matching criterion specific to the study to ensure the collection of specific and detailed information (Morrow, 2005). This type of sampling creates an effective analysis of the phenomenon of interest (Smith et al., 2009). Participants were required to meeting the following criteria:

1. Were a woman between the ages of 25-35
2. Gave birth to a healthy baby within the last five years
3. Not currently in a state of crisis
4. Identified with experiencing any of the following within the first year after birth:
    a. Depressed mood
    b. Excess weight gain or loss
    c. Sleep disturbances
    d. Fatigue
    e. Loss of interest or pleasure
    f. Loss of appetite
    g. Thoughts of suicide or death
    h. Anxiety
    i. Low self-esteem
    j. Lack of sex drive
    k. Agitation
    l. Decreased concentration or ability to think
    m. Feelings of worthlessness, guilt or hopelessness
    n. Anger or easily irritated
    o. Inability to cope
5. Have experienced contemporary norms of mothering impacting their ability to seek help for the postpartum emotional difficulties they experienced
6. Able to commit to an interview lasting 60-90 minutes

I chose the selection criteria to create a fairly homogenous sample that provided similarities and differences within the group of participants (Smith et al., 2009). The criterion of being between 25 to 35 years of age was chosen to create a fairly homogenous sample of participants. The criterion of 'gave birth within the last five years' was chosen to (a) ensure the experiences were recent for ease of recall of information; and, (b) to create a homogenous time period that the experiences occurred in hopes that the participants would share similar experiences of contemporary norms of mothering. As this research examined experiences of women who experienced postpartum emotional difficulties, I mirrored selection criteria based on the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-V) definition of

major depressive disorder with peripartum onset (American Psychological Association, 2013). This definition was used to provide me with a guideline of symptoms that women frequently experience during the postpartum period. A diagnosis of postpartum depression or major depressive disorder with peripartum onset was not required in order for the study to include women who did not seek help.

I created posters to invite women to participate in this study, requiring that they meet the criteria. The posters were distributed for advertisement at various places throughout Saskatoon including West Winds Primary Health Centre; Westside Community Clinic; Saskatoon Community Clinic; Cravings Maternity, Baby and Kids; and Family Service Saskatoon. An announcement was placed online on the University of Saskatchewan PAWS Bulletin Board. I chose these places to distribute posters as they are places that mothers may frequent. I hoped to recruit women with a range of socio-economic backgrounds including a range of occupations, socio-economic status, education, wealth, and place of residence. I did not collect demographic information and cannot speak to the occupations, socio-economic status, wealth, and place of residence of the participants; however, all four women who participated in the study had varying levels of University-level education. Two of the participants answered the recruitment add that was placed on the University of Saskatchewan PAWS Bulletin Board and the other two heard through word of mouth. It is possible that women who had lower levels of education, wealth, and socio-economic status did not see the ads or did not see participation in the study as feasible due to the time needed to participate, the location of the interview, and/or the need for childcare to participate.

In total, six women expressed interest in the study; however, only four women moved forward in the research study. One of the women who did not move forward in the research study disclosed in an email that she was currently in a state of crisis. Since the criteria required that participants not be in a state of crisis, I phoned this woman in an attempt to discuss the limitations of her contribution to the research; however, the woman did not answer her phone. I left a message on the woman's voicemail and also sent her an email thanking her for her interest but denied her participation because of the possible dangers it could cause (see Appendix B: Telephone screening guide). I provided her with a list of community resources that she could contact should she choose to seek help (see Appendix C: Counselling Services Form). The other woman who did not participate had expressed initial interest in the study but did not return the

phone call when she was called for initial screening. The four participants that remained met the required criteria.

Van Den Hoonard (2012) describes that a small number of participants is appropriate for a qualitative research design. Similarly, Smith et al. (2009) believe that a small number (three to six participants) is sufficient for a Master's level thesis because it allows the researcher to study both individual cases and between cases in depth. The goal of IPA is to study a small sample in depth and not to generalize and represent the general population (Smith et al., 2009).

Procedure

All participants responded to the recruitment posters by emailing my email address that was provided. I responded via email asking for their phone number to contact for initial screening. The participants were called and screened to ensure that inclusion criteria were met (Appendix B: Telephone screening guide). If the participant met the inclusion criteria, a date and time for an interview was scheduled. I emailed each participant a copy of the interview questions so that they had time to reflect on their answers before the interview.

The interviews took place in the College of Education building, room #1219, which are interview rooms in the skill development laboratory. This place was chosen as it was accessible to me and would allow for privacy. I began each interview with a conversation that helped to build rapport and to assist the participants in feeling comfortable to discuss their experiences (Smith et al., 2009). The conversation focused on small talk, discussing the participant's background and their family. This portion of the interview was not recorded as it did not include any data that would be pertinent to the research. Informed consent occurred after this initial conversation. After informed consent was discussed, I disclosed my research interest and my own experience with postpartum emotional difficulties to help the participants feel comfortable. I was careful not to elaborate on the contemporary norms of mothering that I encountered to prevent influencing the participants' examples.

Ethical requirements were addressed in a conversational manner which included signing of the consent form which outlined the purpose of the research, limits to confidentiality, choice of pseudonym for the purpose of reporting findings, permission to use excerpts of the interview in the report, permission for audio recording, the right to withdraw from the research, and a check box that asked if the participants wanted to review transcripts from their interviews (Smith et al., 2009) (see Appendix D: Consent form).

Data Generation

A semi-structured, in-depth interview was conducted with each participant (Smith et al, 2009). The participants were asked to elaborate on their experiences with contemporary norms of mothering and help-seeking while experiencing postpartum emotional difficulties referencing the following questions as an interview guide:

1. Remember an experience where you encountered a social expectation of mothering. Can you tell me about this experience with as much detail as possible?
2. Please share with me how this experience affected any emotional difficulties you experienced postpartum.
3. Please tell me about your experience with the decision to not seek help for your emotional difficulties.
4. What would have helped you overcome these barriers in order to seek help for your emotional difficulties postpartum?
5. Is there anything else you think I should know about your experience with social norms impacting your ability to seek help for the emotional difficulties you experienced postpartum?

The semi-structured interview allowed for flexibility within the interview. I asked questions based on the content and in an order that followed a natural flow (Smith et al., 2009). Probes were used to assist with clarity and to encourage the participant to elaborate further. Examples of probes that were used included: (a) What did this experience mean for you? (b) What were the specific barriers you experienced? (c) What was that like for you? (d) Can you tell me more about that? (see Appendix E: Interview guide).

I checked in with participants throughout the interview asking questions such as, “How are you doing talking about this?”; “Are you ok to keep going with the interview?” and, “Are you ok with ending the interview?” The check-in questions were used to check into the sensitivity of the topic and to assess the participant’s level of distress. None of the participants reached a point of distress that required additional assistance. However, during the interview, one of the participants disclosed that, at times, she still experiences postpartum emotional difficulties. I encouraged this participant to seek counselling and provided her, along with the rest of the participants, a list of counselling resources should she wish to seek counselling or other support (see Appendix C: Counselling services form). Each participant was debriefed after the interview

and reminded that the consent form included the contact information for me and my supervisor should they be interested in a copy of the final document.

I then transcribed each interview into a Microsoft Word document. Three of the four participants indicated on the consent form that they were interested in receiving a copy of their transcript for reviewing and editing. I emailed the transcribed interview to the intended participant using a password encrypted file with the password in a separate email. I included the Transcript Release Form for the participant to return indicating they had the chance to review, add, alter, and delete information from the transcript (see appendix F: Transcript release form). The fourth participant who indicated she did not wish to review the transcript of her interview did not receive a transcript release form. However, she signed the consent to participate in the research project and indicated (by placing a check mark in the 'yes' column) that I may use direct quotations from her interview, indicating implied release of her interview.

Data Analysis

The goal of IPA is to examine an individual's lived experience with a specific phenomenon and how that individual makes meaning and understands that phenomenon (Frost, 2011). Using IPA, the present study examined women's experiences with contemporary norms of mothering and help-seeking while experiencing postpartum emotional difficulties. The process of IPA is flexible, iterative and creative (Frost, 2011). Although there is not a prescriptive sequence to analyze data in IPA, Frost (2011) provides guidance that involves four stages of analysis.

The first stage of analysis involved reading and re-reading the transcript to become familiar with the content (Frost, 2011). At this stage, I read, re-read and listened to the interviews while making initial notes on the printed transcript. Initial noting consisted of initial observations, reflections on the data and significant words or phrases that emerged. I also paid close attention to and noted the use of words and language, the content that was discussed, emotions that were elicited and her initial interpretation of the data.

The second stage of analysis involved creating emergent themes from the initial notes and observations. At this stage, I used NVivo, a qualitative data analysis software, to code and organize the data. This process allowed for ease in transferring the verbatim quotes into an excel spreadsheet to create a table of quotes at a subsequent stage. I examined the interviews using a hard copy of the interview to examine the initial notes and an electronic version using NVivo.

Significant quotes were coded using an assigned “node”, referring to the conceptual name given to the quote.

The third stage of analysis involved organizing the nodes based on their similarities in order to create emergent themes (Frost, 2011). Frost (2011) suggests creating a table to organize the themes. I used Microsoft Excel to aid in this process. From NVivo, I downloaded all nodes and saved them to a password protected computer. The nodes were transferred to an excel document and examined for similarities. This process was iterative as I continued to go back and forth between the original transcript and the Excel document, checking each theme in the original context to align with the ideographic nature of the analysis. The nodes were organized together based on similarities and assigned an emergent theme.

The fourth stage of analysis involved creating a final table with emergent themes, direct quotations and line numbers from the original transcript (Frost, 2011). I transferred emergent themes to another Excel document and constructed columns for the theme, direct quotation and line number of the transcript.

I completed these four steps with each participant by paying careful attention to ‘bracket’ and looking at each transcript with a beginner’s mind to prevent any influence from previous interviews (Frost, 2011). After these four stages were complete with each participant, I examined similarities among participants. Themes were considered significant based on their rich descriptions and their prevalence among participants (Frost, 2011). At this stage, I jotted down the emergent themes (initial themes that emerged from the data) from each participant on separate Post-its, and then spread them out and looked at them as a whole. The emergent themes were reorganized into groups based on similarities and are referred to as constituent themes (constituent refers to “a word, phrase, or clause forming a part of a larger construction (HarperCollins Publishers, 2017, p.7)). Each grouping of constituent themes was given a super-ordinate theme (an over-arching theme to describe the groupings of constituent themes (Smith et al., 2009)) that described the themes as a whole. Further, two constituent themes were better understood by breaking them down further into sub-themes (“a secondary or subordinate theme” (HarperCollins Publishers, 2017, p.1)). The hierarchy of themes begins with super-ordinate themes, which are overarching themes that describe the groupings of constituent themes; then constituent themes, which are the themes that emerged in analysis; and lastly, sub-themes, which are used when a constituent theme is better understood by subordinate themes.

Once I was satisfied with the restructuring and organization, I created another table on Excel to document and chart the themes and provide the direct quote and line number from the original transcript. Again, this process was iterative as I checked the data with the original transcript to ensure that it fit the corresponding theme.

The next stage involved writing up the direct themes in the results chapter. Again, this process was iterative to ensure the idiographic meaning of each direct quote aligned with the meaning the participant intended. Analysis continued at this stage and the names of the superordinate themes, constituent themes, and sub-themes changed to better reflect the content. The themes are discussed throughout Chapter Four, followed by a discussion in Chapter Five that integrates the results to existing literature.

Trustworthiness

Establishing validity and trustworthiness is an important factor in qualitative studies. The goal of qualitative research is not to establish results that generalize to the population; instead, qualitative research, specifically IPA, focuses on obtaining insight into the detailed description of a specific phenomenon based on the detailed accounts of few participants (Smith et al., 2009). Yardley (2000) guides trustworthiness in qualitative research through four principles. Smith et al. (2009) further recommend these guidelines. The four principles include (a) sensitivity to context, (b) commitment and rigour, (c) transparency and coherence, and (d) impact and the importance of valid research (Yardley, 2000).

Sensitivity to context refers to knowledge of substantive literature used to situate the data and through demonstrating connection and interaction throughout the interview process and with the data (Smith et al., 2009; Yardley, 2000). To demonstrate knowledge of substantive literature, I conducted a thorough literature review to situate my research with the current literature which focused on postpartum emotional difficulties, help-seeking and contemporary norms of mothering. Connection and interaction were demonstrated through the interview process by providing empathy and recognizing the difficulty that participants might have with speaking about the topic. Sensitivity to context is continued through analysis by paying close attention to the participant's narrative and underlying meaning (Smith et al., 2009).

Commitment and rigour is the second principle that guides trustworthiness (Yardley, 2000). Smith et al. (2009) suggest that researchers can demonstrate commitment through attentiveness to both the participant in the data collection process and through close attention to

the content in data analysis. I demonstrated commitment and rigour by paying close attention to detail throughout the interviews and making sure the participants were comfortable and at ease. Through an iterative analysis and final write-up, I demonstrated commitment by paying close attention during the process. Rigour also refers to being thorough in choosing an appropriate methodology (Smith et al., 2009). Rigour was demonstrated through selecting participants based on their criteria, creating a fairly homogenous sample by outlining particular characteristics required and collecting data through in-depth interviews. Throughout the interviews, I demonstrated rigour by digging deeper when appropriate by asking the participants to further explain their responses.

Transparency and coherence is the third principle outlined by Yardley (2000) and refers to the thoroughness of the description of the research process. I demonstrated transparency by providing a detailed description of participant recruitment and selection, the interview process and the stages of analysis. Coherence speaks to the quality of the final document. I demonstrated coherence by putting myself in the shoes of the reader while carefully editing the final document and hiring an editor to check coherence, grammar and conciseness.

Impact and importance of the research is the final principle outlined by Yardley (2000). Impact and importance refers to conducting research that provides useful and important information to its readers. The research proved to be important to participants and was evident during the data collection process by allowing space for the participants to speak out about their experiences with postpartum emotional difficulties, contemporary norms of mothering, and help-seeking. This research can be useful by providing information to mothers who are facing similar experiences; families and friends who have a loved one who is experiencing postpartum emotional difficulties; and lastly, support workers who are providing support to women who are experiencing postpartum emotional difficulties by providing insight into experiences with contemporary norms of mothering and help-seeking.

Ethics

An ethics application was submitted to the Behavioural Research Ethics Board for approval of research before the study was conducted. It was approved on June 26, 2015, renewed on May 24, 2016, and again on April 24, 2017 (BEH approval #15-192). The ethics application focused on an overview of the study and assessed for confidentiality, conflict of interest, risks and benefits to participants, participant recruitment, consent process, data security and storage.

There are three ethical considerations to note within this study, including sensitivity of the topic, personal bias and confidentiality.

To safeguard risks associated with sensitivity of the topic, I checked-in with the participants during the interview process to assess for negative feelings, thought or emotions that could arise. None of the participants were assessed as being in any immediate danger; however, as noted, one participant disclosed that she still experiences postpartum emotional difficulties at times. I checked-in with her to ensure that she was comfortable with continuing the interview and provided her with a list of counselling resources should she wish to seek support. Some of the participants became visibly upset through crying as they discussed their stories. I checked-in with the participants and provided empathy and support as needed. At the time of the interviews, I had completed SCP 814: Individual Interventions, which gave me the skills to sensitively approach the negative emotions or feelings that arose. Each participant was debriefed following completion of the interview which included the thesis supervisor's contact information and a Counselling Support document that included a list of community counselling resources (see Appendix C: Counselling services form).

Personal bias was possible as qualitative analysis is subjective and I had been personally close to the topic of interest (Smith et al., 2009). To prevent my opinions and experiences from influencing the themes that emerged from participants' interviews, I practiced 'bracketing' (Ahern, 1999). I was careful to be reflexive through the analysis process to prevent any preconceived ideas or notions from influencing the themes that emerged. Ahern (1999) provides guidance for demonstrating an integrative reflexive bracketing to prevent subjective experiences from guiding the research. From Ahern's suggestions, I self-reflected on my own journey taking note of feelings and experiences, I paid close attention to the process of analysis to check-in with myself and my analysis to ensure that I was looking as objectively as possible. From Ahern's (1999) guidance, I noted that new and surprising themes had emerged during analysis; this provided confidence that successful bracketing was employed.

Lastly, I safeguarded against risks of confidentiality breaches by keeping all identifying information confidential and by storing recorded interviews on a password protected computer. Each participant chose her own pseudonym to be used throughout the study. I ensured other identifying information was altered or omitted in the final write-up.

Conclusion

In summary, the current study examined women's experiences with contemporary norms of mothering and help-seeking while experiencing postpartum emotional difficulties. This qualitative research was grounded in a social constructivist theory, employing interpretative phenomenological analysis as the means to analyze the data. Research approval was granted by the Behavioural Research Ethics Board on June 26, 2015. Participants were selected through purposive sampling and were interviewed through in-depth, semi-structured interviews. I described the process of data analysis that was outlined by Frost (2011). This chapter provided a thorough description of how I attended to the principles of trustworthiness as outlined by Yardley (2000). Lastly, ethical considerations of this study were discussed.

CHAPTER FOUR: RESULTS

The purpose of this study was to use Interpretative Phenomenological Analysis (IPA) to examine women's experiences with contemporary norms of mothering and help-seeking while experiencing postpartum emotional difficulties. Results of this study will be presented thematically throughout this chapter in a "case within theme" format, meaning each theme will be supported by excerpts from the participants (Smith et al., 2009, p. 109). Super-ordinate themes, constituent themes, and sub-themes emerged through analysis of the participants' interviews. They will be presented using direct quotes from the participants. The voices of the participants are maintained throughout the chapter to align with the idiographic nature of IPA (Smith et al., 2009).

Direct quotations included in this chapter were minimally altered to protect participants' anonymity and to present the information coherently. For example, ellipses (. . .) were used to omit data within a quote that did not relate to the phenomenon; repeated words and filler words were omitted, such as 'like' and 'ah'; and squared parenthesis ([]) were used to add additional words for coherency of the sentence and to change identifying information, such as names to [husband] or [baby]. Quotes are shown in double parenthesis ("") and indentations throughout the text. Single parenthesis ('') were used to indicate direct speech within a quote (American Psychological Association, 2010). The participants chose their own pseudonym to be used to protect their identity.

This chapter begins with a contextualization of the data and a description of each participant followed by an overview of the experience of contemporary norms of mothering and help-seeking for women who lived with postpartum emotional difficulties. Next, two super-ordinate themes of *Stigma: A Barrier to Help-Seeking* and *Resilience: A Catalyst for Help-Seeking* will be described following their constituent themes and sub-themes. The chapter will conclude with a summary of the results.

Contextualizing the Data

The participants for this study were four women, between the ages of 25-35, who self-reported they had experienced postpartum emotional difficulties within the last five years and experienced contemporary norms of mothering that impacted their ability to seek help. At the time of initial screening and interviewing, the participants could not be in a state of crisis, as per participation criteria. Interestingly, at the time of the interviews, all four women had two children

and all women had varying levels of university education. All of the women were in heterosexual relationships at the time of experiencing postpartum emotional difficulties.

The goal of this research was to describe the themes based on women's rich descriptions rather than their prevalence throughout the interviews and amongst participants; therefore, each theme may not include contributions from all participants. A theme was considered relevant if highlighted by more than half the participants (Smith et al., 2009). Although the passages chosen are represented by a common theme, the content of the passages is unique to each participant. The following is a description of each participant, her experience with postpartum emotional difficulties, and an overview of her experience with contemporary norms of mothering.

Participant One: Ashley

Ashley is a married mother of two girls. She self-reported that she experienced a lot of "anxiety," "anger," "resentment," and "mood flashes." While remembering the postpartum emotional difficulties she experienced, she stated, "I would feel anxious, like my heart was racing." She described feeling "overwhelmed," often experiencing a "mood flash where I would start sweating [because the] baby's waking up and I don't want the baby waking up because I'm not ready to deal with this today." As Ashley experienced postpartum emotional difficulties with both of her children, she stated she was able to "recognize it that much sooner with [second child]."

Ashley's experience with contemporary norms of mothering started at the beginning of her pregnancy:

> The social pressure is, you go online, when do you announce? You're constantly following what babycenter.ca says or what to expect when you are expecting, you know, when do you tell your boss, when do you tell anyone? Right? It kinda starts from there, all those social norms of what to do as a new mom.

When she was asked to recall an experience with a contemporary norm of mothering, she spoke about a barbecue she was expected to have after giving birth to her second child. She shared, "It was very difficult for me because I just wasn't ready. She was two weeks old and I was struggling emotionally and I hadn't really understood why." Ashley was torn between cancelling the barbecue to meet her own needs and hosting the barbecue to meet the expectation of hosting the barbecue so her friends and family could meet the baby.

Ashley stated her experience with contemporary norms of mothering and postpartum emotional difficulties made her feel "heavy" and "locked within yourself." She stated that "you're trying to figure things out and you're constantly at a battle with yourself. You want to do everything that every mom does on Facebook…and you just can't do it." For Ashley, she constantly compared herself to other moms on social media which made her feel inadequate. She shared, "You just think about what you are not doing with [your children] and you internalize it and you just feel heavy."

Participant Two: Alexsis

Alexsis is a married mother of two boys. Her experience with postpartum emotional difficulties started when she was pregnant:

> I really thought that once morning sickness passed that my mental state would improve . . . until I was pregnant with my second, and then I was able to look back and that's when I recognized I was quite sad during pregnancy and just low energy.

Along with low energy, Alexsis stated she had a lot of "anxiety" and "fear, fear that someone might wanna take him away from me if I wasn't a perfect mom." Alexsis felt a lot of "anger," which came as a surprise to her. She shared, "I had no idea that anger was a sign of postpartum depression." Since Alexsis did not know anger was a sign of postpartum depression, she was unaware that she was experiencing postpartum emotional difficulties: "When I got pregnant with my second and the anger went away I realized, I didn't even realize how angry I was and how I was feeling until it went away." She said that her experience changed once she was pregnant with her second: "All of a sudden I just felt genuinely happy, and I realized it had been a long time since I had felt just happy." Since Alexsis then recognized that she had experienced postpartum emotional difficulties, she started to mentally prepare herself. She stated, "I'm gonna be way more careful this time, I'm going to do things like I said, encapsulate my placenta, and do things that I can to try to wave this off . . . and if it comes then hopefully I'll see it sooner."

When Alexsis was asked to remember an encounter with contemporary norms of mothering, she stated that she felt she was "supposed to have everything figured out and I was supposed to know everything." She expressed that she did not have a lot of support as her mom had passed away a few years before. Her initial reaction to the question was not a specific example of a social expectation on her, but more of "an expectation of society." She expressed:

> My expectation of society let me down. I expected to have more help and support, and as the mother I would be this important figure . . . then, all of a sudden I realized no, I'm just the person that brought this wonderful little guy into the world.

Having no support and feeling like she was supposed to know everything, Alexsis stated, "It set the tone for me for the rest of motherhood. I didn't feel like I could be asking as many questions." She felt that she "wasn't supposed to show fear or show uncertainty or show a lack of knowledge, like I had to put on this air of being brave and knowing everything."

Participant Three: Amy

Amy is a single mother of two boys. She experienced postpartum emotional difficulties following the birth of both babies; however, the difficulties were different for each baby. After the birth of her first son, she felt "traumatized." She stated that "the whole process of childbirth triggered all that past [childhood trauma] and I had no idea that was what could have happened." Amy was diagnosed with post-traumatic stress disorder following the birth of her son. Amy shared that she experienced:

> Flashbacks, almost immediately. I couldn't stop replaying the pain. I just could not relax. It was almost like my nervous system was just like absolutely through the roof. If the lights were dim I would panic. It would trigger panic and nightmares, like I was having a lot of nightmares.

Amy mentioned that experiencing this caused her to feel "emotional turmoil" about the trauma that she experienced as a result of childbirth.

Amy felt pressured by contemporary norms of motherhood "starting from the beginning when you have a baby." She felt a lot of expectations from others about bonding with her baby, keeping the house clean and working on her body post-birth. She said she felt "just so much pressure to be what everyone is telling me to be and to do . . . then you just feel like you can't talk about it, right?" Since Amy felt traumatized from her first childbirth experience, she had trouble bonding with her baby: "You can't talk about [not bonding with your baby] cuz it's like if you don't feel all this love towards your baby then people would judge me pretty harshly for that." Amy had emotional difficulties after her second child was born, but believed it was because she separated from her husband at that time.

For Amy, experiencing contemporary norms of mothering, she stated,

> [It] took away from my enjoyment. Instead of seeing the situation for what it was and seeing . . . really just enjoying my son and enjoying my life, everything was about trying to live up to what people wanted and/or even just what my perceptions were of what people wanted and expected.

She added, "You have all those difficult things happening; it's very difficult to reach out. You need someone almost to like reach in there and like extend their hand because you can't. You just—it's like you're stuck there."

Participant Four: Bernice

Bernice is a mother of two children—a boy and a girl. Bernice separated from the partner who fathered her first child and is with the father of her second child. The emotional difficulties Bernice experienced were "really bad anxiety and my symptoms seemed more like postpartum OCD [obsessive compulsive disorder]."

One of Bernice's experiences with contemporary norms of mothering involved post-birth body expectations. She stated:

> The new thing is how skinny you can get right after, how small you stay during pregnancy and how flat your stomach is weeks after. Like that's competition with everybody, and I just kinda refused to be a part of it but, it's just, that seems to be the social things, like, 'look at me two weeks later, I'm already skinny again.'

Bernice also felt the pressure of contemporary norms of mothering from her partner's family. She expressed, "They're pro-formula, like you shouldn't breastfeed any of your kids and I wanted to breastfeed and they're just like, 'oh, just give her the bottle.'" Bernice stated that the family's pressure made her doubt her abilities as a mother. She stated, "It made me question, like, is my milk good enough? Like, cuz she was petite and she took a really long time to gain weight and then they'd always be like 'oh well, we'd take her but you're breastfeeding.'" Bernice felt like she would not receive support because of her choice in breastfeeding.

Bernice's experience with contemporary norms of mothering was "frustrating." She shared, "it would like give me anxiety cuz it feels like everybody's judging me for every choice you make." Feeling this caused Bernice to "isolate" herself. Her experience of emotional difficulties made her "feel like you can't just be happy, just be happy that you have a baby, like you just can't enjoy it."

Contemporary Norms of Mothering, Help-seeking, and Living with Postpartum Emotional Difficulties: An Overview

The experiences with contemporary norms of mothering and help-seeking for these women who lived with postpartum emotional difficulties were complex and unique to each participant. The participants provided rich, descriptive narratives of their experiences with contemporary norms of mothering and how it affected their ability to seek help. Initially, many themes emerged throughout the process of analysis. In the end, some themes were discarded if they did not provide rich descriptions of the themes, if they were only represented by one participant, and/or if they did not fit well with the super-ordinate, constituent, or sub-themes. The experiences of contemporary norms of mothering and help seeking amongst women with postpartum emotional difficulties are illuminated through two super-ordinate themes: *Stigma: A barrier to help-seeking* and *Resilience: A catalyst for help-seeking.* The super-ordinate theme of *Stigma: A barrier to help-seeking* can be further understood through the constituent themes of S*elf-stigma, Unaware of Symptoms,* and *Perceived Stigma: Expectations of Others*. The super-ordinate theme of *Resilience: A Catalyst for Help-Seeking* can be further understood through the constituent themes of *Helping Oneself* and *Seeking Help from Family, Friends, and Professionals* (see figure 4.1). Some of the quotes have overlapping content and could be represented by other themes in the document. Each quote was placed under the constituent theme that best suited the content.

The chosen themes illuminate the participants' experiences with their shift in help-seeking. Initially, stigma associated with postpartum emotional difficulties and not fitting in with contemporary norms of mothering was present. The participants described feeling as though they could not reach out for help because of judgements placed on oneself, not recognizing symptoms of postpartum emotional difficulties and fear of judgements from others. After some time, each participant became aware of their postpartum emotional difficulties and accepted their experiences, leading to helping oneself and seeking help from others.

For example, when Alexsis felt stigma when she realized that she was experiencing postpartum emotional difficulties, she stated that she could not reach out for help because she was "scared of judgment." The only person she confided in was her husband. She shared, "My poor husband was the only person who knew for the first two years when our first was young."

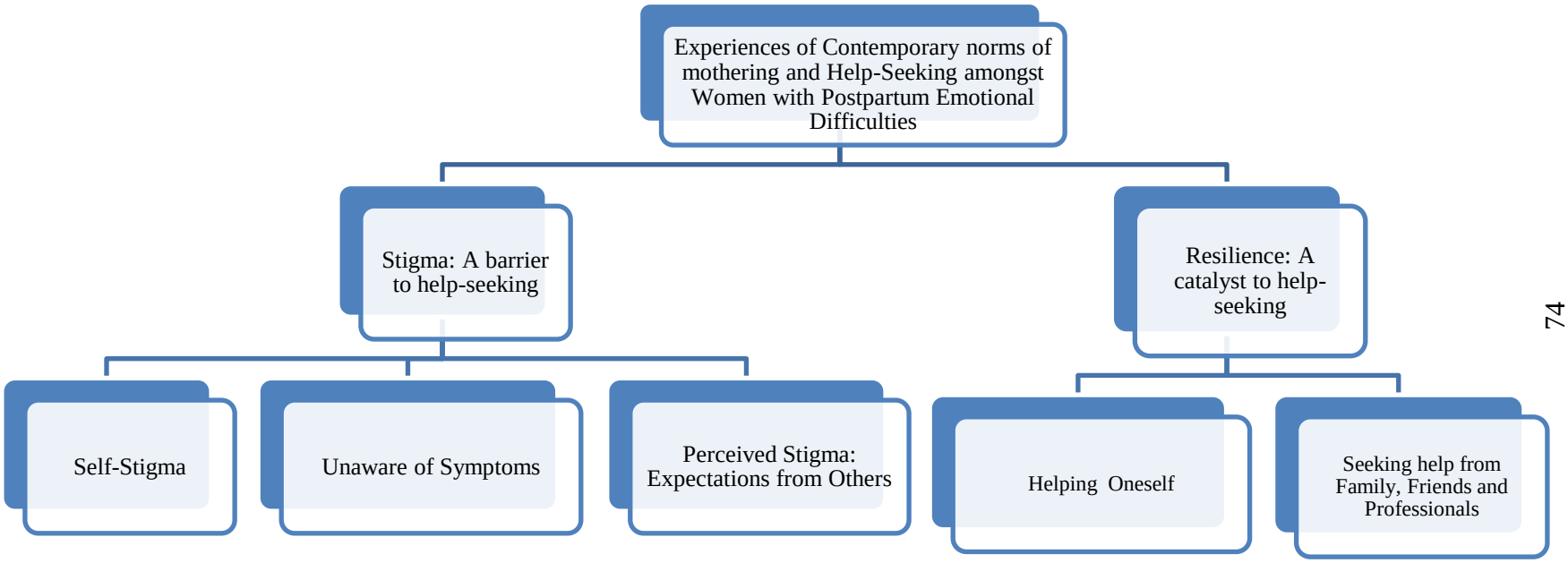

Figure 4.1. Overview of themes

Ashley felt “overwhelmed” by the postpartum emotional difficulties she experienced. She felt a lot of “anxiety” and “anger,” which she did not believe fit into the contemporary norm of what a new mother should feel like. She stated, “I declined going to see my doctor. She suggested that I should be on medication and that I need to talk to somebody about it and I just wasn’t ready to admit that.”

For Amy, she felt “traumatized” after the birth of her first baby leaving her to feel that she “didn’t wanna be a mother anymore.” These feelings were very conflicting for Amy. She shared, “It’s so unnatural as a mother to not want your baby, but it was like, I felt the experience was so traumatizing.” Amy did not feel that she could express her feelings to anybody because she believed “people would judge me pretty harshly for that.” Bernice felt that her postpartum emotional difficulties were “embarrassing.” She lived in a small community and did not feel that she could reach out for help because of the lack of anonymity and her fear of a lack of confidentiality. She was scared that the people she knew at the hospital would “talk amongst each other.”

All four participants described how, over time, their perspectives shifted. They no longer felt shame due to the stigma of not fitting into the contemporary norm of a ‘good mother.’ Instead, once they became aware of their postpartum emotional difficulties and accepted their struggles, they felt confident to seek the help that was needed. The following examples highlight the participants’ experiences with acceptance and awareness of their postpartum emotional difficulties leading to building resilience and seeking help.

For example, Alexsis accepted that she needed to seek help through realizing that she did not want to live in the shadows of her postpartum emotional difficulties anymore. She described the moment that she realized she needed to get help: “Right after my placenta pills ran out, I was back to feeling the way I had after my first. It was just on like a switch, so I knew that I needed something else.” Alexsis had her placenta encapsulated so that she could take it orally. She described hearing that it could improve her mood and decrease the risk of developing postpartum emotional difficulties.

Ashley described realizing that she needed to get help at one of the appointments she had with her obstetrician. She shared, “[My doctor] said to me that I should go back to my GP and take her up on that medication . . . I did go on medication because it was something that was really hard to just pull myself out of.”

Amy stated that she "knew where to find help the second time" when she experienced postpartum emotional difficulties after the birth of her second child. She attended a postpartum support group and regarded the facilitator as a "lifeline" for her, giving her the strength to examine her ideas of what it takes to be a 'good mother.' Amy expressed that the facilitator helped her to realize that "the definition of a good mother is very broad." For Bernice, acceptance was shown through her ability to reach out to talk with a "nurse practitioner" and being prescribed an antidepressant.

This section provided a highlight of women's experiences with contemporary norms of mothering and help-seeking while living with postpartum emotional difficulties. The following sections will further describe each super-ordinate theme and their constituent themes with rich descriptions from the participants.

Stigma: A Barrier to Help-Seeking

Stigma is defined in the Oxford Dictionary as "A mark of disgrace associated with a particular circumstance, quality, or person" (Oxford University Press, 2017, para. 1). In the context of this research, stigma is further differentiated as self-stigma and perceived stigma. Self-stigma occurs when an individual judges him or herself as a result of believing they do not fit in with contemporary norms (Overton & Medina, 2008). Perceived stigma occurs when an individual believes that other people will judge or discriminate them because of mental illness (Sirey et al., 2001).

Bernice and Alexsis described experiencing stigma. For example, Bernice stated, "It was embarrassing" when she discussed talking to the health nurse about the postpartum emotional difficulties she experienced. Similarly stigma was present when Alexsis described completing the Edinburgh Postnatal Depression Scale (EPDS): "The first time around when you get that questionnaire, I didn't answer completely honestly because I was scared of judgments, you know, that it was gonna make me a 'bad mom.'"

Amy and Ashley experienced stigma by feeling their behaviour was 'wrong.' Amy expressed, "I just wasn't normal, right? I was like there's something wrong with me." She added, "I think I was afraid of, just like, how people would react," and "I think a lot of those expectations that were verbalized to me as well from the people in my life, it reinforced that feeling of not being normal." Stigma influenced Ashley to hide her postpartum emotional difficulties from her husband. She shared, "A lot of times I did that [had a breakdown] when he

was at work, cuz then I was alone and he didn't know." Ashley perceived stigma from her family at the beginning of her pregnancy: "In [my husband's] family, when I told them I was pregnant before the twelve weeks I wasn't congratulated, I was condemned because you should not say you're pregnant because the baby could miscarry."

The super-ordinate theme of *Stigma: A Barrier to Help-Seeking* can be understood by considering the following constituent themes: *Self-Stigma, Unaware of Symptoms, and Perceived Stigma: Expectations of Others.*

Self-stigma. The participant's narratives revealed experiences of self-stigma in relation to their postpartum emotional difficulties. These experiences can be further understood through the following sub-themes: *Being Silenced, The Hidden Self,* and *Believing They Failed as a Mother.*

"I couldn't talk about it": Being silenced. The participants' narratives revealed an aspect of being silenced that was unique to each woman. The theme of *Being Silenced* arose from a fear of judgment, concerns about a lack of anonymity, not wanting to admit the experience of postpartum emotional difficulties and the inter-generational transfer of shame. For example, Amy had a traumatic birth experience that affected how she bonded with her baby:

> I felt very traumatized by my birth, especially the first one and that really affected my bonding experience with the baby, but you can't talk about that cuz if you don't feel all this love towards your baby then people—or at least I felt people would judge me pretty harshly for that.

This traumatic experience led Amy to question becoming a mother:

> I just really didn't wanna be a mother anymore and then I thought well, you know, this isn't natural, like maybe there's something going on here, and that's when I realized that I felt that I couldn't talk about it because of the fact that I knew it would be judged so much.

Amy described feeling "horribly depressed at home." She was "bored" but she "didn't feel like I could tell anyone that because how could you be bored as a mother?" In addition to feeling like she could not disclose the complexity of her feelings, Amy also did not have any invitations from anyone to discuss her difficulties: "I felt like everyone just assumed that it would just be great… I didn't feel like there [were] any open doors to discuss what I was going through."

Furthermore, Amy felt isolated in her experience and did not know who she could talk to:

> I don't know who on Earth I would talk to about this. I didn't feel comfortable to my doctor, I didn't feel comfortable with my parents, didn't feel comfortable with my husband, so who do you talk to? It was hard. You feel very isolated.

Amy discussed a situation that led her to feel as though she could not open up to her friend. She described visiting a friend after her friend gave birth. Since she experienced postpartum emotional difficulties, she was worried that her friend could be living with a similar experience. Amy created a care package for her friend hoping it would let her friend know she could reach out to Amy. She stated that her friend "had a completely different reaction. She was like, 'I'm so happy.' She just had a different reaction than how I felt on the inside." Amy then experienced feeling as though she could not discuss her difficulties by saying, "I didn't feel like I could confide in her either." Amy then explained that she felt disappointed that no one reached out to her. She stated, "I would've really benefited from just some more exposure to different experiences, you know? It just kept me feeling alone, I guess you could say just more isolated."

Bernice felt silenced because she lived in a small town and feared the lack of anonymity at the hospital: "You're scared that someone at the hospital is going to talk about it because your friends work at the hospital and you know it's just—you're kinda worried." This concern about a lack of anonymity inhibited Bernice from seeking help.

Ashley was silenced through feeling as though she could not admit her feelings. She shared, "I declined going to see my doctor. She suggested that I should be on medication and that I need to talk to somebody and it . . . and I just wasn't ready to admit that." Ashley also felt she could not admit her feelings to other moms:

> Mommy groups and music groups or something [to do] with baby, I completely, totally avoided those because I just didn't feel that I could pretend, I didn't have it together enough to pretend, and going to those things I knew I would have to pretend, so seeking help in the mommy world was not an option for me.

The theme of *Being Silenced* was apparent for Ashley because she did not know where to seek help. She shared, "It's hard enough to say out loud you're having a problem, let alone, feeling like 'well, who do I go to and where do I go to? Who is safe to go to?'" The fear of experiencing stigma made Ashley question her safety if she reached out for help. She was new to the city and did not know where to go for services. She eventually reached out to a counsellor,

but the waitlist was too long. She was offered phone services, but did not feel that was an option for her because of the demands of a young child.

Ashley continued to experience being silent about her difficulties because she did not have the support system to help her. She shared, "I dealt with it a lot by myself just because I didn't have those external factors like some people have friends or family they can call." She did not feel like she had anyone to turn to that would validate her experience:

> There's not enough, like, sisterhood out there amongst moms, where it's like 'good job,' like 'yay,' 'high-five,' like I'm just looking for a high five, you know, like, it's hard being a mom, there's nothing easy about it and I'm not saying I don't wanna be a mom, I love being a mom. I would never change it for the world, but I just wanna be able to acknowledge that it is hard.

Similarly, Alexsis did not feel as though she had the support available to be able to open up about her experience:

> When I get to that place I feel like no one cares, I feel like no matter who I contacted or what I said, they wouldn't care. I get to a point where I honestly feel like not a single person in the world really loves me or really knows me or really cares about me and what would be the point of seeking help? No one's gonna care enough to do anything anyway.

Alexsis felt as though she was alone. She stated, "I still feel like I'm supposed to do it on my own and I think that's more the barrier than anything else."

Alexsis described that voicing her difficulties meant she was "broken" in the perceptions of herself and others. She shared, "The having to admit I'm still broken, that my fear is I don't want the world to see me as broken, but mostly I don't want to see myself as broken." Alexsis found it difficult to open up because of how she was raised. She shared, "I felt like I had to be more like my mom and keep it bottled up…maybe that's how moms are supposed to be."

"You're not even being your true self and having to mask": The hidden self.

Experiencing shame and self-stigma appeared to influence the participants to behave as though they had to hide their true selves from their family, friends, and their communities. For example, Alexsis believed she had to hide herself from the public:

> You always have to put on that brave face when you go out in public. It doesn't matter how you're feeling a certain day when you've got a commitment or an obligation and you

> have to be somewhere. You have to muster-up, whatever smile inside you can find, and put it on and show the world, and then you feel like you're not even being your true self and having to mask.

In addition, Alexsis recognized that other people are hiding their true selves: "Social media is so great to keep people connected, but it is so bad because everybody is putting on their mask. Everyone is putting [out] the best of themselves." Alexsis felt inclined to hide the emotional difficulties she experienced from her family: "It's the days where, you know, they're off at grandma's house or something and I feel like I'm allowed, like I can totally take off that smiling mask." Alexsis behaved as though she had to hide her true self when she first became a mother:

> From the get-go, I felt as though I was supposed to know everything and I wasn't supposed to show fear or show uncertainty or show a lack of knowledge or confidence. I had to put on this air of being brave and knowing everything.

Believing she had to hide her postpartum emotional difficulties caused Alexsis to experience that "no one in the world really cares." She stated, "It doesn't even matter to anyone else so why seek help because no one else cares."

The experience of living with a hidden self was evident in Amy's narrative as she described herself behaving like she could not be her true self to her husband:

> It took me a long time to admit that I didn't wanna be home, you know? I feel like I was just trying to show my husband that I could be what's expected of me, the mother, and that you know, enjoys taking care of her family and everything like that. But eventually, it's like ya, this is not me.

Amy was feeling the pressure from her husband to stay home and take care of her family, but living this lifestyle was not allowing Amy to be her true self: "I wasn't even considering what I wanted. I was trying to do what was expected of me. I was just trying so hard to be the 'good mom.'" Hiding her feelings made her feel "not normal" and that "something was wrong with me." She stated that her husband further influenced these feelings: "It reinforced the feeling of not normal. I remember him saying things like, 'oh, I thought all women like to be at home and take care of their families."

Similarly, Ashley believed she had to hide her struggles from her husband. Ashley described a time when she wanted to let her child watch more television than was socially acceptable, and acceptable to her husband:

> Probably one of the biggest examples of a social norm that we aren't supposed to do, like, we're not supposed to give our kids TV and we're not supposed to give them tablets…I can't entertain my kids 24 hours a day. As a stay-at-home mom, I can't do it. My three-year-old needs tablet time and she watches Netflix. I do let her watch two episodes in a row and that's more than a half an hour and I just feel like saying, 'so, judge me' but the reality is, I lie about that all the time. I lie to my husband because he only allows the kids to have half an hour a day and when he is home, the TV has to be off and on weekends the TV has to be off…what it comes down to is we break and give them the tablet, but what are we breaking from, why can't they watch Netflix?

Ashley continued to discuss having to hide herself because of her internalization of social expectations:

> Then those social expectations of what a parent should be today, what a mother should do and what a pregnant lady should do, it's a constant internal struggle and I think the hardest part about having postpartum depression after having a baby is you're not able to be yourself because people always expect you to be this ideal.

Lastly, Ashley believed she had to hide the emotions she had about the parenting contribution of her husband:

> Part of my emotional instability is any time I broke because he didn't do something, people would do something and they would judge me and judge him, and I had to hide the fact that my husband wasn't helping me, because if he wasn't helping me then [they would think] he wasn't a good dad; but, he wasn't helping me, it just wasn't a role he chose . . . but if I were to ever speak that out loud to anyone in my circle they would just jump on the dad-hating wagon.

"If you question or go against the ideal, you're looked at like not a good enough mom": Believing they failed as a mother. The participants in this study expressed believing they failed as a mother when describing their postpartum emotional difficulties and not fitting into the contemporary norms of mothering. For example, Ashley described:

> When I couldn't meet the standards of what the social expectations of motherhood were, it meant failure and then, because all of a sudden I was failing to meet those expectations, it just meant—I guess it meant failure but more than a meaning, it felt like failure and it feels like I should be doing more, feels like I am not doing enough.

Ashley stated that she believed she failed at her role as a mother:

> You feel like you don't meet that expectation, so you've failed at your job as a mother, as a wife, as what you're supposed to be as defined by what to expect when you're expecting or babycenter.ca. I was obsessed with what were other people doing and what they were all doing I needed to do. When I couldn't do it, it was just an overwhelming feeling of failure.

For Ashley, comparing herself to contemporary norms mothering made her question herself as the "ideal mother." She stated: "If you question or even go against that ideal you're looked at as not right, 'not a good enough mom.'"

Alexsis described believing she failed as a mother because of her postpartum emotional difficulties:

> After I had my son, the sadness was more like . . . almost came with like an anxiety and fear, fear that someone might wanna take him away from me if I wasn't a perfect mom or the fear that someone might see that I don't know what I'm doing every second of the time.

Alexsis also described believing she was a failure after having an overwhelming emotional day:

> I'm particularly hard on myself where I feel like if I have a really bad day after thinking I was better, then all of a sudden I'm in my own head thinking, 'oh no, you failed, like you know you've been doing so good' and then—'no your actions today, you failed.'

Amy also believing she failed as a mother because of her postpartum emotional difficulties:

> How I would be perceived as a mother—that was a concern to me. I was concerned about the effect on my marriage and I guess just wanting my family to have the very best and just feeling like I couldn't hold it together. So I did feel like I had failed them.

Similarly, Bernice felt that people would question her mothering ability because of her postpartum emotional difficulties. She wondered, "What do they think that I do at home, like am I stable enough to be at home with the kids?" Bernice felt that being perceived as not stable enough would mean that she could not look after the kids. Bernice believed her partner failed after hearing other moms discuss their spouses. She stated, "You go to those groups and then like you got some women like bragging about how much their spouses help and it's just like, 'shut up,

just shut up.'" She did not want to hear about the amount of work that other dads did because her partner was not meeting that standard.

Bernice expressed believing she failed as a mother when she compared herself to other moms:

> You're not quite as happy as you should be and I'm always tired, you know what I mean? Anyways, it's just like you know, people talk about the things, like they go to group yoga's with their babies and stuff like that, and I'm like 'I'm not doing that.' I can't have the energy to like wash my hair most of the days.

"I had no idea that anger was a sign of postpartum depression": Unaware of Symptoms. Postpartum depression and other postpartum emotional difficulties are not often discussed in social networks or some families. As described, stigma surrounding postpartum emotional difficulties appeared to create a silencing effect with the participants on speaking out about their difficulties. A similar effect may influence the public's discussion of postpartum emotional difficulties. Such silencing may not allow other people to recognize the symptoms of PPD when they experience them. The theme of *Unaware of Symptoms* was apparent amongst the participants in this study. Bernice believed that her symptoms were not extreme enough to warrant seeking help. She believed she had to wait until she was experiencing a "meltdown" before reaching out for help. Ashley shared, "was struggling emotionally and I hadn't really understood why."

Amy shared that she also did not recognizing that she was experiencing emotional difficulties:

> At the time I didn't know what was going on. I thought it was normal, to be honest. Like, I thought it was normal to be so . . . well . . . and part of it too was I didn't talk about it because I didn't know how to explain what was going on.

Amy continued by stating, "I was too overwhelmed to even think about seeking help at that time. Again, I thought it was normal. I thought what I was experiencing was normal, so I didn't think I needed help."

Similarly, Alexsis described not recognizing that her postpartum emotional difficulties might have warranted reaching out for help:

> People would talk about it and I would think, 'oh, I'm not that bad,' or 'I don't, why would I need that?' And ya, almost like if I did have to ask for help, how embarrassing

would that be? I just didn't really recognize that it was something that I needed, I didn't feel that I needed help, although, I look back, I know that I did.

"You shouldn't breastfeed any of your kids": Perceived stigma: Expectations from others. The theme *Perceived stigma: Expectations from others* illuminates participants' experiences with either perceived or expressed expectations of contemporary norms of mothering from friends, family, and society. Alexsis stated that she had "expectations of how society would be supportive of me and I was let down by that." Bernice stated, "the media or in television, they portray [mothering] like, you know, it's so easy and everything just kind of flows together, but it doesn't. It's just, you know, like dad's perfect and helps out 50/50 when it's not like that." Many of the contemporary expectations that have an influence on new moms are expectations found online. For example, Amy stated, "You go online and there's all these, like, what moms are doing and all, and then you feel like, 'ok, that's the standard,' and in order to be a 'great mom' then you have to do all these things."

Similarly, Ashley stated:

> There are so many examples on Pinterest of things we should do with our kids and they are wonderful and they are dreamlike, and I would love to do them with my kids every day, but I feel like I can't because I have so many other things to do in a day.

Amy explained that she was "criticized" by others when she was not meeting their expectations for taking care of herself and her house:

> If I'm not taking care of things, if I'm not showering every day, I would get criticized. It was like, 'oh, why didn't you wash your hair today?' Then, of course, it makes it even harder to talk about it cuz then you're like, 'I don't know, why? Should I be able to?'
>
> That was a big barrier, being afraid of the criticism.

Amy stated that people would come over and say to her, "Oh, you need to keep your house clean," or, "you know, 'you need to start working on losing the weight now.'" Hearing these expectations led Amy to wonder "like maybe there was something wrong with me."

Similar to Amy, Bernice also experienced perceived stigma and expectations about her body and her ability to keep her house clean:

> When I was in the hospital with [baby] and I had the C-section, it was the next day and the doctor is like, 'what's this?' And, he like pokes at my belly [and says], 'you still look like you have a baby in there.'

Hearing that from the doctor made Bernice feel "like I wanted to cry and punch him in the face at the same time."

Bernice felt expectations from her family to "make sure the house was clean." She described feeling conflicted because "the health nurse really pushes that like, 'don't worry about the dirty dishes, don't worry about that, like baby comes first.'" However, when she followed these instructions she received opposite pressures from her in-laws. She stated that the expectations from her in-laws made her believe that they did not think she could keep up to the expectation to keep her house clean. She stated that they made her feel like, "Oh, maybe you shouldn't, you can't really do it." Bernice also felt judged for the anxiety that she was experiencing: "It would give me anxiety, it feels like everybody's judging me for every choice you made, so a lot of times you just gotta ignore it or isolate yourself."

Bernice continued to experience perceived stigma from other people around her. Since her in-laws were "pro-formula," Bernice received the message from them that "you shouldn't breastfeed any of your kids." This led her to feel judged about her choices in feeding her baby: "I should be breastfeeding. Even though you can breastfeed, like, the social norm [is that] breastfeeding isn't normal, like you have to be covered and you have to do this." Bernice's baby got thrush, which is "an infection of the mouth and throat with candida" (Oxford Dictionary, 2017, para. 1) and had to be treated an antiseptic called gentian violet; as a result of this, she was met by her in-laws with the criticism of, "well, maybe you shouldn't be doing it [breastfeeding]."

Similarly, Ashley felt stigmatized about her choice to breastfeed: "My mom really, really discouraged me [from] breastfeed[ing]. She thought breastfeeding was disgusting and you should not do that. My mother-in-law formula-fed so for me to breastfeed, I had no support from either side." However, Ashley received conflicting messages from her loved ones. She stated, "My husband really wanted me to do it [breastfeed] because he read a lot of books, which is another pressure because men are getting involved in what you should do as a mom."

Ashley's narrative continued to express how she experienced being stigmatized by society "anywhere you go, the big thing is, 'what can your child do?'" explaining that she feels judged when people compare her daughter's abilities to their child's abilities. She stated that it is "frustrating" when others judge her child's abilities and makes her feel "like they just called your child stupid." She described an example of experiencing judgement if her child was not potty-trained by the age of three: "You're completely totally judged because your child is three and

they peed their pants." Perceiving stigma from others left Ashley believing she is "always feeling wrong, because somebody always knows the right answer, whether it's the right answer or not they feel it is, and they have no problem letting you know that." Ashley described a woman who she felt had an opinion about the size of Ashley's baby:

> At swimming lessons with [child], she was seven months old and overweight, like twenty-seven pounds at seven months and she's off the charts, the doctors talked to me about it and I had to measure her formula, so I had a lot of pressure because now my baby is too big! So it's not good if they're too small, but now also it's not good it they're too big. So we're in swimming lessons and she's in a bathing suit and I'm not feeling self-conscious about my daughter being in a bathing suit because she's seven months old and one of the moms said, 'Have you seen a doctor with her because she's really fat?' And I was really taken back because like this woman called my baby 'fat.'

Ashley felt "bothered" by this comment stating that judgments like this are "hurtful to me, it's hurtful to my little girl and it's hurtful to society."

Alexsis described experiencing expectations and stigma from family members that that influenced her ability to speak about her postpartum emotional difficulties: "I felt like if I screwed up, that my in-laws were gonna wanna take my child from me." Alexsis described a memory of when she was a young child being told about her grandmother's experiences with postpartum emotional difficulties:

> I just remember as a kid no one really talked about it very much and I . . . I know that it happened, but it's only been brought up a handful of times maybe, but the very first time the story came out, someone said, 'oh ya, grandma went a little crazy, or she had to go to the hospital because she was a little crazy,' like it was something she had done wrong and I grew up thinking that.

When asked if this memory affected her ability to speak out about her difficulties, Alexsis replied, "oh, ya… that very well could be kind of where it sprang up at the beginning like I was supposed to keep it a secret."

Summary of Stigma: A Barrier to Help-Seeking. Stigma was present in all four participant's narratives of experiencing contemporary norms of mothering and postpartum emotional difficulties leading to their decision to not seek help at that time. It was further understood through the constituent themes of *Self-Stigma, Unaware of Symptoms* and *Perceived*

Stigma. The constituent theme of *Self-Stigma* was comprised of sub-themes of *Being Silenced, The Hidden Self,* and *Believing they Failed as a Mother.* These sub-themes described participants' experiences with feeling as though they were unable to speak about their postpartum emotional difficulties, believing they had to hide their experiences and their emotions from family and friends, and believing they failed as a mother when comparing themselves to contemporary norms of mothering. The constituent theme of *Perceived Stigma: Expectations from Others* described the participants' experiences of contemporary norms of mothering that emerged as judgements and expectations from their friends and families.

Resilience: A Catalyst for Help-Seeking

Resilience and help-seeking emerged in the narratives of all four participants; however, it was more prevalent in the narratives of Amy, Alexsis and Ashley than in the narrative of Bernice. During the interview, Bernice did not seem comfortable elaborating on her experiences. At one point during the interview, Bernice asked if anyone in the hall could hear her. I wonder if the discomfort Bernice felt when describing her experiences was due to still living with the stigma associated with postpartum emotional difficulties. However, given the richness of resilience that was discussed in the interviews, I realized the importance of including it in this section even though Bernice will not be represented as often as the other three participants.

According to the Oxford Dictionary, resilience is defined as "the capacity to recover quickly from difficulties" (Oxford University Press, 2017, para. 1). Additionally, it is "the capacity to respond to pressures and tragedies quickly, adaptively, and effectively" (Graham, 2013, p. xxv). It allows an individual to cope with both daily stressors and uncommon stressors. In the context of this research, resilience is experienced by the participants through overcoming the self-stigma and perceived stigma they experienced, realizing that there are many definitions of a 'good mother' and coping with their postpartum emotional difficulties so they could continue to be the best moms that they could be. Although the initial reaction of these women was not to seek help and to withhold from speaking about their difficulties, through helping oneself, inner strength, awareness of their experiences and support from others, the participants built resilience to overcome their postpartum emotional difficulties. They were able to find the support they needed to realize they are and always were the 'best moms' they could be and to cope with the postpartum emotional difficulties they experienced. The following section will describe how Alexsis, Amy, Ashley and Bernice built resilience within themselves which

assisted them to seek help from others. It can be further understood through the constituent themes of *Helping Oneself* and *Seeking Help from Family, Friends, and Professionals.*

Helping Oneself. The theme of *Helping Oneself* is shown through the participants' narratives that describe methods they used to cope with their postpartum emotional difficulties and the stigma they felt because of not fitting into contemporary norms of mothering. It can be further broken down into the sub-themes of *Inner Strength, Supporting the Self, Being the 'Best Mom' You Can Be,* and *Resilience through Awareness.*

"Just being alive is something to be proud of": Inner strength. *Inner strength* was apparent within the narratives of each participant. It was manifested through the participants describing themselves challenging social expectations, gaining a sense of pride and finding an outlet through physical strength such as exercise. For example, Alexsis felt inner strength through challenging the actions and judgments of others: "I've tried very hard to come to the understanding you can't control what other people do, you can't control what they say, their actions, that's up to them. I can only control what I allow into my world." She has also expressed that she has challenged the expectations she felt from social media and put limits on her social media use:

> The whole social media thing was one topic that I thought about quite a bit lately and how I think it's good, but it also could be bad because everyone's putting out the best of themselves. You have that social expectations of well, everybody else is fine and everybody else can handle this and look at that person—she's got more kids than me and she's always smiling in her photos and you know, sometimes social media is not always the best thing but I do find that when I'm feeling dark, I try to avoid it because it's not gonna bring benefit to me in those moments.

In addition, inner strength was shown through Alexsis describing feeling pride about overcoming the postpartum emotional difficulties she faced. She shared, "[I feel] a little proud that I've had to endure something difficult, but that I'm still enduring and I'm still getting through." Her pride was evident in her comment, "When you've had a really, really dark day where you've thought it'd be all better if I wasn't alive, then some days feeling just being alive is something to be proud of."

The participants fostered *Inner Strength* by gaining resilience through exercise. Alexsis stated, "meditating and breathing and all sorts of things with yoga have helped me with the

depression a lot." Bernice described that she would sometimes "go for walks" and go to the gym to cope with the difficulties she faced. Ashley described that she, "walked a lot with my first. I just tried to find that outlet, just find my silence." Amy expressed:

> I heard that exercise was good for depression, so I just asked my husband if he would watch the baby for an hour while I went to the local gym and I would just run. That was kind of how I managed it, the endorphins, it was almost like I could actually feel it, I was like, 'ok, this is working.'

It seemed that exercise was a means to not only gain physical strength but also mental strength by influencing the participants to cope with the postpartum emotional difficulties they experienced.

Lastly, Bernice expressed experience with postpartum emotional difficulties by stating: "It kinda like strengthens you a bit and then it's something you can laugh about now, but it's just going through it is hard." In the end, Bernice came out stronger because of the difficulties she overcame. She made meaning of her suffering by finding her strength.

"It's going to be ok": Supporting the Self. The theme of *supporting the self* emerged through the participants challenging negative thoughts, challenging assumptions, and using self-affirmations. For example, Alexsis challenged her reaction to the judgments she felt from others:

> You can't control what other people say. You can't control what they think. You can't control what they do. If they decide that they're gonna be judgmental about it, then I guess that's their issue and I don't need to really worry about them being there for me in the future.

Alexsis felt compelled to challenge her thoughts and keep herself from being affected by the stigma she felt from others. She realized that if she was being judged then that meant the person judging her is not a supportive person in her life. She described initially feeling that judgements made her feel like, "I was supposed to keep it a secret but then I thought about how destructive that obviously was." Instead, she described that she would, "wear it on my sleeve and then if people judge me and think, 'oh, I used to think she was tough and strong and now she's weak' then ok, fine, think that about me." Thinking this way inspired Alexsis to realize that experiencing emotional difficulties "is not something to be ashamed of."

Alexsis continued to support herself by describing that the passing of time has made her stronger and better equipped her to deal with the difficulties she's facing: "The longer I've dealt

with either the depression, or just the longer I've been a mom, the easier it is for me to try and say 'Ok, it's ok to feel sad but I shouldn't act on it.'" Alexsis described reminding herself to use her breath when she feels her postpartum emotional difficulties increasing:

> I feel like breath can be very powerful and that's our thing is when we're getting really upset, "ok, deep breath in, deep breath out," and when I'm on my way down, I can often recognize it and that's what I do. I would breathe.

Supporting herself and using the mantra of taking a deep breath has allowed Alexsis to cope.

Similarly, Ashley supported herself through the use of affirmations: "I just kept saying to myself, 'it's going to be ok, it's going to be ok.'" Ashley stated that when she experienced emotional difficulties with her first baby, she held onto "a hope and a prayer" that the difficulties would improve. As a result of this experience, when Ashley had her second baby, she knew her difficulties would pass: "A lot of it is knowing it's going to get better with your second because it did get better with your first." She said that she repeated to herself: "It's going to be better; tomorrow is going to be better; it's going to be another day and it's going to be better with time; I just have to get through it; I just have to get through." Ashley would often remind herself of the value of having a child and the choices she made around child-rearing: "For me, it was just telling myself, 'Ok [Ashley], you wanted to do this; you were given this gift, you were blessed with this child and you'll work this out. You can do this!" She said she keeps a vision board (a visual representation of goals that an individual would like to achieve which will help them visualize improved life experiences (Burton & Lent, 2016)) with an affirmation on it: "It's on my vision board, 'you have done enough today.'"

"We do the best we can with what we have": Being the 'best mom' you can be. This theme was highlighted by the participants challenging their perceptions of the socially accepted definition of "good mom" and realizing that a good mom is someone who tries her best and does the best that she can at that time, within her circumstances. For example, Amy reminded herself, "It's ok for me to have my own [definition of a good mom]. I don't need to take on everyone else's and, you know, the definition of a 'good mother' is very broad." Amy acknowledged,

> "I did my best, right? You can't beat yourself up for something you didn't—you know, you're just trying to get through something and I think I am actually. I was shocked at how I did get through that, you know? I'm always like 'how on Earth did I do that?'"

Amy expressed pride and amazement at the resilience she gained through overcoming a really tough time. She expressed that she coped through knowing she did her best:

> I think, just wanting the best for my son and that kind of overrode any feelings I had in anything else. That was the main thing; I was just very driven to do what was best by him and to fulfill what I felt like a mother should be. I guess those created—they created goals for me, kind of distracted from how I felt at the time. I guess that's kind of how I got through it.

Amy's motivation to be the 'best mom' she could be helped her overcome her postpartum emotional difficulties.

Ashley felt that she was doing the best job she could, and she expressed that this message should be given to all parents:

> The overall message is as parents we do the best we can with what we have and we shouldn't be judged for that; we should just be ok with that. It's ok to be me today, the best parent I can be today. Tomorrow it might change; a month from now it might change; a year from now it might change; but I was never a bad mom. I did the best I could with what I had, and that truthfully is what we need to tell ourselves every day as parents. When our children are upset with us because they couldn't have something or they felt we did something wrong, we can simply say, 'Listen, I did the best I could with what I had and you just have to be ok with that.'

Ashley felt that trusting herself and the choices she made was important when faced with perceptions of contemporary norms of mothering:

> It's just allowing yourself to be ok with that. I mean we're all going to get caught up in what everyone else is doing because we all want to give our kids the same opportunity as everyone else, but at the end of the day we can't meet that expectation because of financial reasons, emotional reasons, physical reasons, vehicle reasons, whatever. It doesn't make us bad parents. It just makes us parents who are parenting the best that they can.

Ashley continued to emphasize that as parents, people need to remind themselves that "you're just trying to do the best you can." She mentioned that reminding herself of this is what "motivated me further" to cope with the postpartum emotional difficulties she faced.

Once Alexsis gained resilience towards her postpartum emotional difficulties, she felt like she had the strength to show the world that she was being the best mom she could be despite feeling sad:

> I'm sure being sad did not make me a better mom, but I think that that drive—the feeling like, 'I'm gonna show the world.' I had this feeling like if I mess up or if I make too big of a mistake that someone's gonna swoop in and say 'you know, you're not good enough' but I thought 'Nope, I'm gonna show you guys' . . . I'd like to think that it drove me to wanna just always be the best mom I could be just so I could say well I gave it everything.

Alexsis felt that if she did the best she could then no one could say she was not a good mom. She mentioned she always "prioritizes" her kids and does what she can to "put them first."

"If I'd known a bit more going in to things, maybe I would have recognized it sooner": Resilience through awareness. Awareness of living with postpartum emotional difficulties gave the participants clarity and strength to become resilient and seek help. For example, Alexsis felt that if she had been aware that she was experiencing postpartum emotional difficulties she would have been able to get help sooner. She shared, "Part of me doesn't want to scare them about it, but at the same time, if I'd known a bit more going in to things maybe I would have recognized it sooner." She explained that she likes to share her experience with her friends who are in childbearing years so that she can help them to become aware that postpartum emotional difficulties exist.

Ashley stated, "I think I was always aware that what I was feeling was wrong; it wasn't who I truly was. Knowing how to deal with it and accepting how to deal with it was the other thing." The hardest part for Ashley was she did not know how to seek help with the difficulties that she was facing.

Alexsis, Ashley, and Amy shared the perception that they recognized their postpartum emotional difficulties sooner after the birth of their second babies. Ashley stated:

> Knowing that I had postpartum with [first child] the first time around and then being able to recognize it that much sooner with [second child] because I was just like 'no, this is how it was with the first.' It wasn't just because [first child] cried all the time and she was colicky, it was because I emotionally and hormonally am imbalanced.

Ashley expressed she would often use the examples from the theme self-talk to remind herself that the postpartum emotional difficulties got better with her first, so therefore they will improve after her second child. Ashley would say to herself:

> I just have to get through cuz the second month is going to be harder than the third month. Slowly, slowly it's going to be better and you, like a lot of it is just a hope and a prayer that it's going to get better and a lot of it is you knowing it's going to get better with your second because it did get better with your first.

Reminding herself that it would get better helped Ashley to believe she could cope with her postpartum emotional difficulties.

Alexsis did not realize that she was experiencing postpartum emotional difficulties until she was pregnant with her second child. Realizing this allowed her to really enjoy the feeling of happiness throughout her second pregnancy. Because of this experience, Alexsis was able to recognize when her mood changed after her second birth. She described noticing her mood was changing:

> After he was born and my placenta pills ran out, I started feeling it come on again and it was quite sudden. It was very easy to all of a sudden recognize the past behaviour and say 'oh ya, this is just like before.' It was much easier to identify and I don't know that I registered and thought 'oh, I need help' but I thought I need to do something.

Alexsis felt that recognition motivated her to seek help the second time:

> I was a lot more honest with my doctor. I'm not going to lie, the first time around [after the birth of her first son] you know when you get that questionnaire, I didn't answer completely honestly because I was scared of judgment or you know that it was gonna make me a 'bad mom' so the second time [after the birth of her second son] I thought no, I'm going to say exactly how I feel.

Recognizing her postpartum emotional difficulties were returning motivated Alexsis to seek support from her doctor: "I knew that I needed something else like I needed to do something else whether it be counselling, whether it be medication, I was open to my doctor's suggestions."

Alexsis stated that becoming aware of her postpartum emotional difficulties was "kind of a relief to realize there's a reason, maybe I'm not really as mad at my husband all the time as I think I am. Maybe there's more of a reason." Having awareness gave Alexsis the validation that her experience was because of postpartum emotional difficulties. She described feeling

motivated: “Maybe I can get through this and at the end, there’ll be a way for us to be happy again. I think that relief was probably one of the biggest feelings.” Having awareness allowed Alexsis to know that there was an end to her struggles.

Amy shared the experience of being more aware of postpartum emotional difficulties when she had her second child. This awareness helped her because she knew how to get help:

> It was a lot different with the second one. At that point I kind of knew where to find support. There was this one girl who ran a postpartum support group and I was the only one who would go every week but she was like a lifeline for me. She was one of those people that said, ‘you come . . . even if you just sit here, we’ll listen to soothing music.’ She was just available and very understanding and aware of how difficult postpartum can be. That made a huge difference for my second experience.

When Amy experienced postpartum emotional difficulties after the birth of her first child, she did not realize that the difficulties she faced were not common. When she brought over the care package to her friend who just gave birth and discovered her friend was happy she realized she needed to seek help. She shared, “[It was] one of the realizations for me that maybe something wasn’t right about my experience. Maybe this isn’t normal to be having such an emotional time, a difficult time.” She stated she felt relieved upon noticing this: “It was good because it did help me see that there was something going on, maybe something was wrong.” Amy stated that her friend’s reaction “opened the door to me examining more of what was actually going on.” She described realizing “like the more I couldn’t live up to the standards and things, the more I thought like maybe there’s something wrong with me.” In addition, Amy felt giving up breastfeeding provided more relief from the difficulties she faced. She said:

> As soon as I didn’t have all that, I think it was a lot of the hormones, but there was a lot more clarity for me and I felt a lot more like, ok, I feel for the first time in a long time like myself. Then it was like ok, what’s been going on, it was more realizing that this has just been so natural.

Once the participants became aware of the difficulties they faced, they were able to seek help and begin coping.

Lastly, the theme *Resilience through Awareness* was also present in Amy’s narrative. She described that she now feels motivated to bring awareness to society:

> I hope I can educate my peers as I go through this. I would really like to be involved in postpartum visits. You know how there's like homecare nurses do homecare, why not have postpartum home care if you identify someone? It's like social work in a way, but mental health homecare. I feel like when you're at home it's so hard to even just get out of your house, but if you can have someone who's reaching out, who identifies that you're struggling and that can, you know, bring those visits in, come to you, I think that would be such a valuable resource.

Amy described feeling motivated to help others by reaching out and providing education and support to other woman who have identified experiencing postpartum emotional difficulties and who may be isolated.

Seeking help from family, friends, and professionals. All four of the participants eventually sought help from family, friends or professionals. Alexsis sought help from friends, her husband and child and her general practitioner; Ashley received support from both her child and her obstetrician; Amy received support from a postpartum support group; and Bernice sought help from family and a public health nurse.

Alexsis described feeling the most comfortable confiding in other women who were also of childbearing age. She shared, “I definitely feel like I can talk about it with my sister-in-law and other girlfriends who are moms.” She found once she opened up to these women, she learned that “most of my friends have experienced some form of sadness or know someone very close to them who has.” She felt that this allowed her to bond closer to the women. She described, “there’s that bonding over a common factor.” Alexsis continued by stating that she felt her generation was the most supportive. She shared, “I feel like, for the most part, my generation is a lot more understanding.”

Additionally, Alexsis reached out to her doctor for support. When she noticed her postpartum emotional difficulties returning after her second child, she thought, “No, I’m going to say exactly how I feel.” She then described how she opened up to her doctor:

> I answered it [EPDS] completely honestly and [the doctor] looked at me and she read the answers and looked up and said, ‘I’m not happy with these responses.’ I said, ‘I agree with you, I’m not happy with the answers either, what do we do?’

Alexsis stated that opening up created the space for change. She shared, “I don’t know what changed, but all of a sudden I wanna talk about it.” Seeking help and having her difficulties

recognized by her doctor allowed Alexsis to shift her perspective and try to get help for her postpartum emotional difficulties.

Alexsis sought help from her husband and children. She shared, “The only thing that I have found will snap me out of it is if [my husband] tells me, ‘your kids love you,’ or if they’re there and they’ll run in and give me a hug.” She continued to talk about the support from her kids by stating, “My kids will always snap me out of it, no matter how dark it is, but I usually don’t get to those dark places when they are around.”

Similarly, Ashley also received support from her child. She stated:

> With my second I would say I got over it a lot faster just because I had the first child. I got snuggles and I got ‘I love you moms.’ I really felt like the ‘I love you moms’ and the hugs got me over it.

Ashley continued by describing the feedback and support from her child was “the best medicine” and it was the “only affirmation we’re doing something right.” She mentioned that the support from her child helped her to come to terms with the impact of contemporary norms of mothering that she felt from society. She stated:

> When our kids give us a hug and an ‘I love you’ it’s a lot easier to wipe off the social expectations of today. When your kid says ‘I love you’ because you’ve done something right, because your child loves you, because you love your child and when it comes down to it that’s really what it should be about.

Additionally, Ashley received support from her obstetrician. At an appointment, Ashley described the obstetrician noting that her “mood and demeanor had completely changed from being pregnant.” She said her obstetrician suggested she mention her postpartum emotional difficulties to her general practitioner. In her general practitioner’s office, Ashley “failed it [the EPSD] the third time and I did go on medication because it was something that was really hard to just pull myself out of.”

Similarly, Bernice received support from professionals in the town she lived in. She shared, “I went and talked to the mental health nurse all the time and I went to those breastfeeding clinics.” She mentioned that the nurse helped shift her perspective on her daily priorities. She stated, “the health nurse really pushes that like ‘don’t worry about the dirty dishes, don’t worry about that, the baby comes first.’” This helped Bernice to feel less pressure about the perceived expectation to keep her kitchen and house as tidy as expected.

Bernice described seeking help from her family and friends. She described, “I go to my mom’s and she’ll hold the baby, or I think a couple times I even just went there to shower so I can actually wash my hair and dry it.” This support from her mom allowed her to have some time to focus on self-care. Bernice stated she sought help from a friend she felt could relate to her experience. She was struggling with feeling that she and her partner were not sharing the parenting roles equally. When she opened up about this, her friend replied that her own husband “probably changed like three diapers and they have three kids, so she’s like don’t feel bad.” The shared struggle and being able to relating to her friend helped Bernice with the frustrations she was feeling.

Lastly, as mentioned, Amy received support from a postpartum support group after the birth of her second child. Amy described attending a childbirth education session with her mom. A woman who ran a postpartum support group spoke at the event. Amy did not realize it at the time, but the woman later had an impact on her: “She just got up and shared her experiences and at the time I didn't think anything of it but then later on I remembered her from that.” Amy described how much of a positive impact it had on her wellbeing. To Amy, finding this postpartum support group was “everything.” She described that “one person can make the difference” and that having one person who supported her could “make or break that experience.” Amy expressed that the woman helped her develop resilience to her postpartum emotional difficulties. She stated:

> She was the only one there; the only one that I felt was like a safety in a lot of ways. It was so nice to know that someone just understood and was just there, like could just be there and listen and had so much knowledge about it as well. She helped me, gave me a lot of insight into what was going on it was a lifeline, really, it was everything.

In addition, Amy stated that this woman helped her to challenge her own thoughts about her experience. She shared:

> [She helped] to reframe some things that were happening in my head. If you have people expecting this of you, she would help me realize, well you don’t have to have those expectations of yourself and that doesn’t make a good mother. The dialogue really helped change my perspective which helped me relax more into my role.

Amy realized that she did not need to define herself as a mother by her perceptions of contemporary norms of mothering. She went on to talk about the support she experienced: “She

was able to help me see that I wasn't crazy, [I was] just going through emotional difficulties and that a lot of women do go through it. It kept it from feeling so isolating." This helped Amy to realize that she was not "alone" and the difficulties she experienced were also felt by others.

Summary of Resilience: A catalyst for Help-Seeking. Resilience was described in individual ways by all four participants. This theme was further broken down into the constituent themes of *Helping Oneself* and *Seeking Help from Family, Friends and Professionals.* In *Helping Oneself,* the women shared experiences of developing resilience through inner strength, supporting the self, building awareness of their postpartum emotional difficulties and realizing that the definition of a good mom is multi-faceted and unique to each person. In *Seeking Help from Family, Friends and Professionals,* the participants described coming to terms with their difficulties and accessing the support of friends, families, and professionals.

Summary

This chapter explored the lived experiences of women who self-reported living with postpartum emotional difficulties, their encounters with contemporary norms of mothering and how this influenced their ability to seek help. Two super-ordinate themes emerged: *Stigma: A Barrier to Help-Seeking* and *Resilience: A Catalyst for Help-Seeking.* The super-ordinate theme of *Stigma: A Barrier to Help-Seeking* was expanded through the constituent themes of *Self-Stigma, Unaware of Symptoms,* and *Perceived Stigma: Expectations from Others.* The constituent theme of *Self*-Stigma was comprised of the sub-themes of *Being Silenced, The Hidden Self,* and *Believing They Failed as a Mother.* The super-ordinate theme of *Resilience: A Catalyst for Help-Seeking* was understood through the constituent themes of *Helping One-self* and *Seeking Help from Friends, Family, and Professionals.* The constituent themes were further expanded and anchored in the women's narratives describing themes such as *Inner Strength, Supporting the Self, Being the 'Best Mom' You Can Be,* and *Resilience Through Awareness* describing their inner strength, supporting the self, realizing their own inherent qualities that make them the best moms they can be, becoming aware of their experiences so they can cope with and overcome them, and finding the strength to reach out to family, friends and professionals.

Overall, this chapter describes the stories of how Ashley, Alexsis, Amy, and Bernice experienced contemporary norms of mothering and help-seeking while living with postpartum emotional difficulties. Initially, all four participants felt that they were unable to seek help and

felt stigmatized by not fitting into the contemporary norms of mothering. In the end, however, each woman described overcoming the stigma and building resilience so that they could seek help for their difficulties.

CHAPTER FIVE: DISCUSSION

This study examined women's experiences with contemporary norms of mothering and help-seeking while living with postpartum emotional difficulties. Research shows that few women seek help for postpartum emotional difficulties (Fonseca et al., 2015; Henshaw et al., 2013) and, for those who do, many face barriers to help-seeking including structural barriers, lack of knowledge of postpartum depression symptoms, stigma, shame, fear, and discomfort discussing symptoms (Corrigan & Watson, 2002; Edwards & Timmons, 2005; Fonseca et al., 2015; Foulkes, 2011; Leham, 2015; Sword et al., 2008; Thomas et al., 2014).

In the reviewed literature, contemporary norms of mothering impacted women's experiences with help-seeking (Leham, 2015; Thomas et al., 2014). For example, Leham (2015) examined the lived experience of maternal mental illness, stigma, and accessing healthcare in women in Saskatoon. Similarly, Thomas et al. (2014) examined constructs that impacted help-seeking for women who experience postpartum emotional difficulties by examining an online discussion. However, neither of these studies specifically examined the impact that contemporary norms of mothering had on help-seeking. Thomas et al. (2014) examined an existing chat room; consequently, the researchers were unable to directly ask participants about their experiences with contemporary norms of mothering to gain a deeper understanding of the impact on help-seeking. Leham (2015) examined a population that was already accessing health care; therefore, her participants did not present with barriers to help-seeking. Missing in the literature was a thorough examination of women's experiences with contemporary norms of mothering while living with postpartum emotional difficulties and how these experiences related to help-seeking. I wondered what themes would emerge if women were directly asked about their experiences with contemporary norms of mothering and help-seeking while experiencing postpartum emotional difficulties.

This chapter will summarize the current findings and integrate these findings into the extant literature. Next, strengths and limitations of the study will be discussed followed by implications for practice and future directions.

Summary and Integration of the Findings with Current Literature

Through exploring women's experiences with contemporary norms of mothering and help-seeking for postpartum emotional difficulties, it was evident that the participants in this study initially experienced barriers that prevented them from seeking help and were associated

with perceptions of contemporary norms of mothering. This finding supports existing literature that reported contemporary norms of mothering as a barrier to help-seeking (Barney et al., 2006; Edward & Timmons, 2005; Fonseca et al., 2015; Foulkes et al., 2011; Leham, 2015). However, an interesting and surprising finding in the current study was the degree of resilience, and subsequently help-seeking, that was discussed despite the women initially feeling as though they were unable to seek help. The topic of resilience when experiencing postpartum emotional difficulties has only appeared in a few select pieces of literature (Hain, Oddo-Summerfeld, Bahlmann, Louwen, & Schermelleh-Engel, 2016; Shaikh & Kauppi, 2010).

In the present study, two super-ordinate themes emerged from the data that were shared amongst the participants: *Stigma: A Barrier to Help-Seeking* and *Resilience: A Catalyst for Help-Seeking*. The super-ordinate theme of *Stigma: A Barrier to Help-Seeking* could be further understood through the constituent themes of *Self-Stigma, Unaware of Symptoms,* and *Perceived Stigma: Expectations from Others.* Furthermore, the theme of Self-Stigma was comprised of the sub-themes *Being Silenced, The Hidden Self,* and *Believing They Failed as a Mother.* In the first sub-theme of *Being Silenced,* participants described believing they were unable to speak about their postpartum emotional difficulties. The second sub-theme of *The Hidden Self* illuminated the participants' experiences with believing they had to hide their experiences and their emotions from family and friends. The third sub-theme, *Believing They Failed as a Mother,* described the belief of being a failure that the participants experienced when comparing themselves to contemporary norms of mothering. Participants also described belief of failure because they were struggling with postpartum emotional difficulties. The constituent theme of *Unaware of Symptoms* revealed participants' experiences with not recognizing the severity of their symptoms, and therefore not realizing they needed to seek help. Lastly, the constituent theme of *Perceived Stigma: Expectations from Others* described the participants' experiences with perceiving judgement and stigma from their family and friends expressed as expectations as to how they should be acting or behaving as a mother.

The super-ordinate theme of *Resilience: A Catalyst for Help-Seeking* could be further understood through the constituent themes *Helping Oneself* and *Seeking-Help from Family, Friends, and Professionals.* Furthermore, the constituent theme of *Helping Oneself* was comprised of the following sub-themes: *Inner Strength, Supporting the Self, Being the 'Best Mom' You Can Be,* and *Resilience through Awareness.* In the first sub-theme, *Inner Strength*, the

participants described experiences where they gained resilience through challenging contemporary norms of mothering and finding healthy ways of coping to deal with their postpartum emotional difficulties (e.g., exercise). The second sub-theme, *Supporting the Self,* described participants challenging negative thoughts and using self-affirmations to help themselves through their postpartum emotional difficulties. The third sub-theme, *Being the 'Best Mom' You Can Be,* described participants challenging self-stigma and realizing that they were being the best moms they could be despite the initial belief of failing as a mother. The fourth sub-theme, *Resilience through Awareness*, described how participants felt motivated to seek help once they became aware that their postpartum emotional difficulties warranted it. Lastly, the constituent theme of *Seeking Help through Family, Friends, and Professionals* described the participants' experiences with seeking help for their postpartum emotional difficulties. These findings are integrated into the current literature in the following paragraphs.

Stigma: A Barrier to Seeking Help

Stigma was a common underlying theme the participants experienced in relation to contemporary norms of mothering and their postpartum emotional difficulties; and, this experience created a barrier to seeking help. As mentioned, current literature supports the finding of stigma as a barrier to help-seeking (Barney et al., 2006; Edward & Timmons, 2005; Fonseca et al., 2015; Foulkes et al., 2011; Leham, 2015). This section can be further understood through the following constituent themes: *Self-Stigma, Unaware of Symptoms,* and *Perceived Stigma: Expectations of Others.*

Self-Stigma. Self-Stigma occurs when individuals judge themselves as a result of believing they do not fit in with contemporary norms of mothering (Overton & Medina, 2008). The participants described experiences of self-stigma which created a silencing effect that prevented them from speaking out about their experiences and seeking help. Fonseca et al. (2015) support the notion that stigma is a barrier to help-seeking, noting that 9.4% of their participants listed stigma as a barrier. Furthermore, Fonseca et al. (2015) described self-stigma in the form of fear of others discovering their mental health concerns which was a significant barrier to help-seeking. Similarly, in the current study, Bernice described fearing the lack of anonymity in a small community if she were to seek help.

The participants in the current study shared the experience of believing they had to hide their symptoms from others. For example, Alexsis and Ashley described being fearful of being

honest about their symptoms with their doctors. This supports Leham's (2015) findings that described a theme of secrecy where participants felt they had to hide their maternal mental health experiences from friends, family, and professionals. Furthermore, Leham (2015) described participants who did seek help for their experiences; however, they were hesitant to disclose to their family or friends if they were taking pharmacological treatments. Similarly, Edward and Timmons (2005) described participants who wanted to hide their experiences with postnatal illness from physicians because they feared negative consequences.

The participants in the current study shared the experience of believing they were failing as a mother. For example, all four participants described believing they were not meeting the standards of contemporary norms of "good mothering" and believing that this meant they were failing as a mother. This supports Thomas et al.'s (2014) findings that described women who experience postpartum depression believing they failed to align with the standards of "good mothering." Likewise, Edwards and Timmons (2005) described participants who felt as though they were "bad mothers" for experiencing postnatal mental illness.

Unaware of symptoms. The participants shared the experience of being unaware that the depressive-like symptoms they experienced aligned with the criteria for postpartum depression or other postpartum emotional difficulties. They described believing that their symptoms did not warrant seeking help, not understanding why they were struggling, and thinking the emotional difficulties were 'normal'. Similarly, Fonseca et al. (2015) described their participants as experiencing a lack of knowledge about peripartum depression and participants not knowing if their problems warranted help-seeking. Sword et al. (2008) described themes that discussed normalization of symptoms being a barrier to accessing help. The participants described believing their experiences were normal; their family and friends minimized their symptoms and responded as though it were normal to experience postpartum emotional difficulties; and lastly, participants described health care providers normalizing their symptoms instead of offering appropriate support. Believing their experiences were normal prevented the participants from seeking help for their symptoms.

In addition, Foulkes (2011) described participants who believed that health care providers were unaware of their symptoms. They further described experiences of their symptoms being unnoticed because maternal mental health was not specifically monitored. However, Shaikh and Kauppi (2010) revealed conflicting experiences with normalization of symptoms. In their study,

participants believed that normalization of symptoms helped them to challenge the self-stigma thereby leading to building resilience towards the postpartum depression symptoms through understanding they were not alone with their experiences.

Perceived stigma: Expectations from others. The participants shared the experience of perceiving stigma from family and friends about their postpartum emotional difficulties by not fitting into their perceptions of contemporary norms of mothering. This supports Thomas et al.'s (2014) findings where they described that women felt judged or penalized by others because they did not fit into the contemporary norms of mothering. Similar to the current study, Thomas et al. (2014) described participants believing the perceived stigma from others prevented them from seeking help. Furthermore, Thomas et al. (2014) describe instances where participants believed the important people in their lives were judging them as failing to be a good mother. In the current study, Bernice described her family having expectations about the cleanliness of her house and her choice to breastfeed. Similarly, Ashley felt stigmatized by her family about her choice to breastfeed. This supports Leham's (2015) findings that described women being stigmatized or judged by others for their maternal mental illness.

This section focused on the stigma that the participants experienced due to perceiving that they did not fit in with contemporary norms of mothering and for experiencing postpartum emotional difficulties. An important consideration is the negative connotations that surround postpartum emotional difficulties and PPD. Is it possible that the medical community has pathologized the difficulties that occur when transitioning to becoming a mother? Instead of framing these potential difficulties as psychologically abnormal or unhealthy, is it possible to think of them as the result of a normal transition period? If the difficulties are not clinically significant, such as clinical depression, suicide ideation, or psychosis, it is possible to view the difficulties that mothers experience as a normative transition period that includes a myriad of tensions, struggles, and emotions. This is a very important alternative to consider when thinking about the mothers of today. Instead of striving to be "perfect mothers," mothers should focus on doing the best they can at any moment, seek support when needed, and strive to accept their difficulties as part of their shift to motherhood.

Resilience: A Catalyst for Help-Seeking

As mentioned in Chapter Two, the experience of resilience amongst women who live with postpartum emotional difficulties is an understudied phenomenon. Resilience appearing as a

theme in the current study was surprising. I had anticipated that the participants would speak to many barriers that they encountered that prevented them from seeking help. However, after the interviews, I was surprised by the amount of resilience that each participant portrayed, despite initially believing they could not seek help due to the stigma of not fitting into the perceived mould of contemporary norms of mothering. Resilience in PPD is an understudied phenomenon; however, two recent pieces of literature support the findings of the current study (Easterbrooks, Kotake, Raskin, & Bumgarner, 2016; Hain et al., 2016). The current study described resilience using two constituent themes: *Helping Oneself*; and *Seeking Help from Family, Friends, and Professionals*.

Helping oneself. The participants shared experiences of helping themselves cope with both their postpartum emotional difficulties and the stigma they experienced along with it. For example, Alexsis and Bernice shared the experience of helping themselves through the use of inner strength. Alexsis showed inner strength through challenging social expectations and contemporary norms of mothering by realizing that she did not have to listen to, or be affected by, the expectations of others. She continued to show inner strength by showing pride for overcoming the postpartum emotional difficulties she experienced. Bernice discussed finding strength through overcoming her difficulties. This supports Hain et al.'s (2016) findings that discussed that resilience can moderate the effects of antepartum depression (APD) and postpartum depression (PPD). Their research suggested that a higher level of resilience decreases depression during the antenatal and postpartum periods (Hain et al., 2016). The researchers defined resilience as "a personality trait, i.e. a stable ability to modulate and control one's affective state and to adequately adjust to burdens" (Hain et al., 2016, p. 121). Hain et al. (2016) conducted a study in Germany that examined both risk factors and protective factors for APD and PPD. The findings of the current study are similar; for example, both Alexsis and Bernice developed resilience through helping themselves by adjusting and coping with the postpartum emotional difficulties they experienced. Furthermore, Bernice and Alexsis discussed using exercise as a means to cope with their postpartum emotional difficulties. This supports Shaikh and Kauppi's (2010) findings that describe self-care activities to cope with PPD (eg., exercise).

Ashley and Alexsis shared the experience of supporting the self by challenging negative thoughts, challenging assumptions, and using self-affirmations to promote resilience in the face of postpartum emotional difficulties and the stigma they felt from others. Alexsis described

continuing to support herself through the use of breathing techniques and self-affirmations. Similarly, Ashley adopted affirmations as a way to help her cope. Similarly, Shaikh and Kauppi (2010) discussed a theme of nurturing oneself specifically through developing a positive outlook and taking time for oneself which supports the current theme of helping oneself. Shaikh and Kauppi (2010) discussed strategies that their participants used to cope with PPD that included developing a positive outlook on life by looking for the positive experiences amongst the PPD. Similarly, in the current study, Ashley discussed realizing that her difficulties were going to diminish and telling herself that she would get through the difficult times, thus adopting a positive outlook on her experiences.

Furthermore, the participants in the current study shared the experience of realizing that they were being the 'best moms' they could be. Amy discussed realizing that she can have her own unique definition of what makes a good mother. Ashley discussed accepting that she was doing the best job as a mother that she could. Alexis discussed that her postpartum emotional difficulties motivated her to be a better mom. These examples are supported by Shaikh and Kauppi (2010) through the theme of nurturing oneself through obtaining a positive outlook.

Lastly, the participants in the current study shared the experience of becoming aware of their postpartum emotional difficulties which helped them to cope and build resilience for subsequent births. Alexsis described feeling that she would have sought help sooner had she recognized that she was experiencing symptoms of PPD. Furthermore, the section on stigma discussed the participants describing that they were unaware that their experiences warranted the need to seek help. Being unaware of their experiences speaks to the need for more awareness of postpartum emotional difficulties and PPD so that women and their families can recognize symptoms sooner. Similarly, Sword et al. (2008) described that once women are aware of their symptoms, they are more likely to seek help. Shaikh and Kauppi (2010) support the notion that there is value to increasing awareness of PPD. Additionally, their participants felt compelled to help raise awareness of PPD to work towards decreasing the stigma attached to it. In the current study, Amy also felt compelled to raise awareness about PPD in the community after her experience with postpartum emotional difficulties.

An important and interesting finding of the current study was the recognition and awareness of postpartum emotional difficulties that arose after the birth of a second baby. Alexsis, Ashley, and Amy shared the experience that they were able to recognize their

postpartum emotional difficulties after birthing their second children and were more inclined to seek help at that time. Ashley also discussed coping with her postpartum emotional difficulties the second time through remembering that she eventually overcame her first experience with postpartum emotional difficulties. Alexsis and Ashley described feeling safe and motivated to reach out to their doctors the second time. Amy discussed that she knew where to seek help after she had her second baby.

Seeking help from family, friends, and professionals. All four participants spoke of seeking help from family, friends, and professionals; however, help was not sought right away. It seemed as though it was deferred until the participants overcame the self-stigma and perceived stigma and began to develop resilience within themselves. Alexsis described finding comfort in confiding in other women who were also mothers, describing the bond that emerged when she realized that other women experienced similar postpartum difficulties. Alexsis also mentioned seeking support from her husband, and eventually her general practitioner, after experiencing postpartum emotional difficulties after the birth of her second baby. Ashley and Alexsis shared the experience of finding comfort and support from their first-born children which helped them through difficult times after their second birth; Bernice described seeking support from professionals such as the mental health nurse and breastfeeding clinic, and from her family and friends; and, Amy described joining a postpartum support group when she noticed her postpartum emotional difficulties after the birth of her second child. She reported the facilitator of the postpartum support group helped her to realize that she was not alone in her struggles.

The notion that seeking support from friends and family helps to build resilience supports the findings of Shaikh and Kauppi (2010) who described women building resilience through seeking support from other mothers, asking partners and family members to share in the mothering responsibilities, and accessing professional services. Contrary to this notion, Hain et al. (2016) found that social support only provided a protective factor against developing PPD, not moderating existing PPD. However, their study did not examine the quality and quantity of social support received, and they pondered if women in their study expected more support from their loved ones which subsequently lessened their perceptions of the support they were given (Hain et al., 2016). The current study supports Sword et al.'s (2008) and Thomas et al.'s (2014) findings that discussed the importance of receiving social support as a means to cope with PPD Sword et al. (2008) described that participants felt more likely to seek help when they had

supportive relationships within the health care system. As Thomas et al. (2014) reported, women who sought help from female family members, support groups, and spiritual connections described positive help-seeking experiences.

In addition, Sword et al. (2008) described that timeliness of care is important for help-seeking. This was evident in the current study. Ashley described a barrier to receiving help by being told there would be a year-long waitlist when she called a counselling agency. This was discouraging for Ashley who recognized that she wanted and needed help right away. Similarly, Bernice described that she had to wait for a call from the mental health nurse instead of being able to access services herself. Similarly, Leham (2015) described participants expressing that their health care providers recognized their need for interventions for PPD and expressed the importance of receiving care in a timely matter.

Strengths of the Study

This study has several strengths. First, it contributes to the growing body of literature examining contemporary norms of mothering and help-seeking for women who live with postpartum emotional difficulties. As I noted, previous literature discussed contemporary norms of mothering as a barrier to help-seeking without providing in-depth detail into this experience. The current study asked participants specifically about their experience with contemporary norms of mothering and how it impacted their ability to seek help which provided literature to fill in the gap.

The second strength of this study is the specific methodological approach used to frame the research question, theoretical perspectives, and analysis of the data – Interpretative Phenomenological Analysis (IPA). The theory of phenomenology within IPA provides a theoretical perspective to examine an in-depth exploration of a lived experience to derive an essence of the experience (Smith et al., 2009). Through a phenomenological lens, I examined in detail the lived experience of a small sample of women who had experience with contemporary norms of mothering and help-seeking while living with postpartum emotional difficulties. Using the idiographic theoretical approach within IPA, I examined each case individually and found the particular meaning for each individual (Smith et al., 2009). Lastly, using the hermeneutic theoretical approach within IPA, specifically the hermeneutic circle, I examined the phenomenon within each individual, and then together as a whole to examine it between cases (Shinebourne, 2011; Smith et al., 2009).

IPA is also used to help researchers understand the mental processes of the participants, specifically looking to understand their thoughts and perceptions about the phenomenon (Smith, 2004; Smith & Osbourne, 2003). Additionally, IPA attempts to understand the phenomenon from an "insider's perspective" (Smith et al., 2009). From this perspective, the researcher attempts to understand the phenomenon by making meaning out of the participant's perspective. (Smith et al., 2009).

From this research and using IPA, I was able to gain an in-depth understanding of how women experience contemporary norms of mothering and help-seeking for postpartum emotional difficulties. The themes from this study may be valuable to the broader population. For example, a woman who has shared similar experiences can feel supported and less isolated by reading the participants' experiences. She could also gain insight into building resilience to her own postpartum emotional difficulties. Mental health professionals and any professionals who work with women during the postpartum period can gain insight into the stigma surrounding postpartum difficulties that women could experience. They could also use the section on resilience to help women build resilience within themselves.

Third, I chose a semi-structured interview to engage with the participants about the phenomenon. Semi-structured interviews allow for flexibility within the interview process. This allowed for the participants to lead the discussion. Since a goal of IPA is to gain an insider's perspective, the flexible interview schedule paved the way for the participants' experiential expertise to emerge (Smith, et al., 2009). The interviews were guided by a set of questions; however, I deviated from the guide and followed the direction of the participant. The interview started out with an experiential question asking the participant to describe a specific experience, thus giving the participant space to become comfortable talking (Smith et al. 2009).

Fourth, the homogeneity of the sample is a strength of the study. Although the purpose of qualitative research is not to make generalizable assumptions to the broader population, it is beneficial to remain as homogenous as possible to understand similarities and differences between participants. Not only did all four participants fit the specific criteria for the study, but also they shared similarities such as having two children and some form of university education.

The fifth strength of this study is the impact that the detailed narrative accounts of their experiences had on the participants. The participants were eager to share their experiences and were motivated to help decrease stigma through making discussion around PPD more common

in society. Each participant reflected on the importance of studying this phenomenon in hopes that more women would feel safe and supported to seek help for their postpartum emotional difficulties. Sharing their stories appeared to provide a source of catharsis for the women and validated their experiences. One participant in particular noted that sharing her experience with a friend led the way for her to share her experience in this research. She hoped that this would help make a difference for other women who may be experiencing PPD. Another shared that her experience motivated her to help other women and provide education on the topic. Participating in this research study provided an opportunity for the participants to feel less isolated in their struggles knowing that others were participating in the study and research was being conducted on this important topic.

Lastly, is the contribution to the extant literature of building resilience to postpartum emotional difficulties. This study describes how the participants built resilience within themselves which motivated them to seek help from mental health professionals and doctors for their postpartum emotional difficulties.

Limitations of the Study

There are a few limitations of this study worthy of mention. First, even though using a semi-structured interview is a strength of the study, it is also could be a limitation. Since I followed the participants' lead, each participant provided a narrative that was unique and specific to her experience; therefore, each participant had a slightly different interview. In addition, as I am a novice researcher, I also could have asked the interview questions in a different way or probed deeper into some of the responses that I received. Probing questions were asked throughout the interviews, however when I read over the transcripts I noticed areas that I could have probed deeper. I then noted additional probing questions in the "review panel" of the Microsoft Word document to ask the participants to elaborate on the subject further when they were reviewing the transcript. Examples of additional probing questions that were asked included: "what was it like for you to feel . . .?" and, "how did it feel to experience . . . ?" Not every participant asked to read over their transcript. For those who did ask to review their transcript, when I emailed their document to them, I noted that I had added additional questions and asked them to answer them. However, none of the participants answered any further questions. There may be many reasons why they were not answered. First, I did not list this as a requirement for the study. The participants might have felt they had already shared all that they

needed to share. Second, if the participants did not open the document using Microsoft Word, they might not have seen the extra questions. If the participants reviewed their transcript on their mobile devices, they would not have seen the extra questions.

Second, as the phenomenon of contemporary norms of mothering can have multiple meanings, I could have provided a definition for the participants to follow and describe. However, I wanted to follow the idiographic nature of IPA and delve into the experiences of the participants without leading them; therefore, I left the interpretation of contemporary norms of mothering to the participants. This could have left participants with some confusion as to what contemporary norms of mothering meant.

Considerations for Future Research

Postpartum depression is a common topic in the literature. Less common is research discussing experiences with contemporary norms of mothering and help-seeking while experiencing postpartum emotional difficulties or PPD. Additionally, research focusing on resilience once postpartum depression or other postpartum emotional difficulties have developed is also scarce. The current study added to the literature on PPD by discussing stigma in relation to contemporary norms of mothering as a barrier to help-seeking and resilience as a catalyst to help-seeking. However, this study raised questions regarding help-seeking for PPD and building resilience to prevent against developing and/or moderating the symptoms of PPD.

From a preventative perspective, future qualitative research could examine women who do not develop PPD to examine the factors that helped to protect against developing PPD. Specifically, a researcher could aim to talk with women who are at risk of developing PPD, such as women who have had previous mental health difficulties or antenatal depression, but who did not develop PPD. Additionally, future research could examine women who were not affected by stigma to examine their resilience factors that protected against the pressures inherent in contemporary norms of mothering. The current research described women who did not initially feel that they could seek help for their postpartum emotional difficulties. However, this research did not specifically examine women who felt able to seek help. More qualitative research could examine this phenomenon to examine what motivates women to seek help.

Research describing women's experiences of postpartum emotional difficulties could examine other mental health difficulties that could be comorbid with PPD. For example, one of the participants in the current study revealed that her birth experience uncovered past traumas

leading her to experience PTSD-like symptoms. Future qualitative research could examine the birth and post-birth experiences of women who have experienced past traumas and how this affects their mood post-birth.

As mentioned, the four women who participated in the study had varying levels of University education. It is possible that having a higher level of education could have influenced the research process and outcomes. Future research should aim to include women from varying levels of socio-economic status. Additionally, since all four women were in a heterosexual relationship at the time of experiencing postpartum emotional difficulties, future research should aim to include participants who are single mothers and/or in same-sex relationships.

Considerations for Mental Health Professionals

The themes that emerged in this study provide insight into the influence of contemporary norms of mothering on women who experience postpartum emotional difficulties and the impact that they have on help-seeking experiences. The findings from this study may be useful for mental health practitioners, midwives, nurses, and doctors who work with mothers, especially in the first year post-birth. The insights and themes that were described in this study may provide awareness to these professionals by helping them gain an understanding of the challenges that new moms face especially when they experience postpartum emotional difficulties. The themes in this study suggest that women who experience postpartum emotional difficulties initially experience self-stigma and perceived stigma when they do not believe that they live up to contemporary norms and expectations of mothering. The stigma that was felt amongst the current participants created a barrier to seeking help for their postpartum difficulties. Specifically, the women described believing they were unable to speak about their postpartum difficulties to friends, family, and professionals; they believed they had to hide their difficulties from others; they placed judgements on themselves and believed they failed as mothers; they were unaware that their difficulties were a sign of possible postpartum depression; and, they described perceiving stigma from others because of the difficulties they faced.

When working with new moms, mental health practitioners may want to explore the contemporary norms of mothering that women perceive to help decrease the belief that they do not fit into the mould of what makes a “great mom” and realize the individual strengths that they have as mothers. They may want to discuss and normalize the difficulties that can occur when women experience postpartum emotional difficulties and help the women to see that they are not

alone with their struggles and that many women also experience the same difficulties. Mental health professionals may want to assist clients to define their own definition of good mothering to realize that they do not have to fit into the mould that society or other people hold up for them. In the current study, Amy described finding great solace in the postpartum depression support group that she attended because the woman helped her to realize that there are many definitions of what makes a mother a "good mother" and that provided her with insight into what she was experiencing. Amy described that the facilitator of the postpartum support group helped her to realize that she did not have to listen to others' expectations of society's cultural norms of mothering; she realized she could change her perspective of herself and her situation.

Mental health practitioners may want to become aware of, and discuss, stigmatization that can occur with women who experience postpartum emotional difficulties. From this, they could help women shift perspectives and empower them to rise above the stigma so they are not affected by it. Lastly, mental health professionals may want to help their clients develop resilience and find their own inner strength to help them cope with their postpartum emotional difficulties. As Hain et al. (2016) suggest, promoting resilience during the prenatal period helps to prevent PPD from occurring and may decrease the intensity of PPD if it occurs.

Greater awareness of postpartum emotional difficulties needs to be made available to the general public. Midwives, nurses, and doctors who work with pregnant mothers may want to provide education about the postpartum emotional difficulties that women may face so that if women experience these difficulties, the dialogue has already been started and hopefully they will feel more comfortable discussing their difficulties. If more awareness is available, then women will be able to recognize when they are experiencing these difficulties and when the difficulties warrant help-seeking. Greater awareness can also decrease the stigma that is attached to postpartum emotional difficulties. If society is more aware, friends and families of women who are new moms will recognize postpartum symptoms in mothering and be able to provide greater, more responsive support to these moms. Mental health practitioners, social workers, midwives, nurses, and doctors may want to put more energy into preventative awareness by providing education opportunities to new mothers, pregnant mothers, students, and other health care workers so that more professionals are trained to recognize the symptoms of postpartum emotional difficulties.

To promote further awareness of postpartum emotional difficulties, I conducted a review of the literature that explored assessing for postpartum emotional difficulties. I found an article by Boland-Prom and MacMullen (2012) that uses a biopsychosocial approach to assessing for postpartum emotional difficulties. Through using this model, midwives, doctors, and nurses can help women to become aware of and understand their postpartum emotional difficulties. If women can become aware of their postpartum emotional difficulties sooner rather than later, then it is hoped they will feel confident to seek help. In addition, this model assesses for anxiety, obsessive-compulsive disorder, and bipolar disorder which may not be recognized in postpartum women.

Using the "Model Assessing Maternal Adjustment (MAMA)" in Education, Assessment, and Intervention

Two themes emerged in this study that brought attention to the importance of awareness when working with mothers experiencing postpartum emotional difficulties. Under the superordinate theme of *Stigma: Barrier to Help-Seeking* was the theme *Unaware of Symptoms*, and under the superordinate theme of *Resilience: A Catalyst to Help-Seeking* was the theme *Resilience through Awareness*. All four of the participants spoke of initially not recognizing that their experiences showed symptoms of PPD. Since they were unaware of what they were experiencing, they did not seek help or professional support. Three of the participants spoke of how they were able to cope and seek help once they recognized what they were experiencing.

To assist other women who might experience PPD and professionals who work with prenatal or postnatal women, Boland-Prom and MacMullen (2012) propose the MAMA model, which uses a biopsychosocial approach to understand perinatal moods such as postpartum depression and other postpartum emotional difficulties. More understanding about PPD may surface through bringing awareness to the multifaceted experiences that women have when they are dealing with postpartum emotional difficulties. The MAMA approach widens the PPD lens to include anxiety, obsessive-compulsive disorders, and bipolar disorders; it assesses women through a biopsychosocial lens, including understanding the women from a biological, psychological, and social perspective; it incorporates the health and temperament of the baby to assess for risk of PPD; it assesses women within their own environment looking for pertinent risk factors such as poverty; and, it expands the PPD timeline up to the end of the first-year postpartum. Boland-Prom and MacMullen (2012) propose that the MAMA approach can be

utilized by professionals who work with new and expectant mothers for assessment and intervention and for mothers to use on their own for self-assessments.

The biological domain of the MAMA approach examines women's health before and during pregnancy (Bolan-Prom & MacMullen, 2012). It examines diagnosed illnesses; alcohol, drug, or smoking dependency; sleep; nutrition; stress levels; and, connection to medical care. The psychological domain examines a variety of moods and clinical disorders. It examines anxiety symptoms from anxiety sensitivity to panic attacks and post-traumatic stress disorder; bipolar disorder symptoms, gathering information about previous mood fluctuations; and, OCD symptoms such as obsessions and compulsions that could appear during the prenatal and postnatal time periods. The social domain examines social support for mothers and their interactions with their babies (see table 5.1).

Table 5.1: Model Assessing Maternal Adjustment (MAMA)

Biological

Nutrition	Good nutrition	Poor nutrition	• Inadequate nutrition • Eating disorders
Sleep	Optimum sleep	Disturbed sleep	Extreme fatigue
Health (mom)	Healthy	Medical risk factors	Chronic illnesses
Alcohol, illegal drugs, smoking	No use	Occasional use	• Chemical dependency • Smoking last trimester
Stress	Low stress	Manageable stress	Extreme stress (interpersonal or environmental)

	Psychological		
Depression	Pregnancy blues Postpartum blues	Depression	Depression w/ psychosis
Anxiety	Minimal worry	Anxious	PTSD, panic attacks, or OCD
Mood swings	Minimal lability	Labile mood	Bipolar disorder
Sense of control	Sense of control (work and family)	Variable control	Lack of control
	Social		
Family	Partner present, supportive family	Inattentive or pushy	Abusive, unavailable, critical, or intrusive
Social (friends or groups)	Access to other parents and previous social networks	Contact with social support is less than mom desires	Isolated from expected social supports
Work (boss)	Supportive	Some expectations & some flexibility	Work production primary concern
Work (coworkers)	Supportive-practical and emotional support	Some support-possible complaints or resentments	Inflexible-expects demands be met or consequences
Work environment	Flexible-family friendly policies	Provide only legally required leave	Hostile work environment, penalizes mothers

		Baby	
Health	Healthy	Some medical concerns	• Low birth weight • Serious illness
Temperament	Easy or adaptable	Fussy	Colicky, unsoothable

Note: Continuum: MINIMUM PROBLEMS ↔ SEVERE PROBLEMS

(Boland-Prom & MacMullen, 2012, p. 729)

Using this table, professionals and women who experience postpartum emotional difficulties can assess for the severity of their experiences. If they relate to more experiences on the left, they may have minimal problems; if they relate to more experiences on the right, they may have severe problems and should seek help accordingly.

Conclusion

The purpose of this study was to examine women's experiences with contemporary norms of mothering and help-seeking while experiencing postpartum emotional difficulties. Current literature examining postpartum emotional difficulties revealed that contemporary norms of mothering presented as a barrier to help-seeking; however, the literature did not look deeper into the contemporary norms of mothering and the impact it had on help-seeking. The current study sought to examine the experiences of four women who experienced postpartum emotional difficulties and who felt their help-seeking was impacted by contemporary norms of mothering.

The results of this inquiry revealed that contemporary norms of mothering affected the women in many ways and prevented them from seeking help for their postpartum emotional difficulties; however, despite initially feeling as though they could not seek help, all four of the women's narratives revealed an aspect of resilience and help-seeking that eventually occurred. Two major findings are revealed in this study: *Stigma: A Barrier to Help-Seeking* and *Resilience: A Catalyst for Help-Seeking.*

Initially, all four of the participants described feeling as though they were not able to seek help. They were impacted by contemporary norms of mothering which created a self-stigmatizing and perceived-stigmatizing barrier. The women shared experiences that described how they could not seek help due to the silencing effect of stigma, believing they were a failure

as a mother, believing that they had to hide their postpartum emotional difficulties from others, and being unaware that their symptoms were in fact symptoms of postpartum depression. The women also described perceiving stigma from friends and family about the postpartum emotional difficulties they experienced. The stigma that each woman faced prevented them from seeking help initially; however, all four women described building resilience leading to seeking help from within and from others.

The narratives of all four women described instances of resilience and strength that motivated them to eventually seek help for their postpartum emotional difficulties. Three of the four women described becoming aware of their symptoms when they experienced them after the birth of their second child except this time they did not want to suffer in silence. The participants described building resilience within themselves through inner strength, challenging the contemporary norms of mothering, realizing that they were being the best mothers they could be, using self-affirmations to support themselves, and coping through breathing techniques and exercising. The participants described reaching out to mental health professionals and/or doctors and being honest about their postpartum emotional difficulties when they experienced them a second time which allowed them to receive the support they needed.

As mentioned, research showed that few women seek help for PPD (Fonseca et al., 2015; Henshaw et al., 2013). This study examined women's experiences with contemporary norms of mothering while living with postpartum emotional difficulties and identified how these experiences related to help-seeking. Through this research, it is hoped that the themes will encourage more women to seek help for their PPD or postpartum emotional difficulties. The themes from this study can be used to help more mothers not feel alone in their struggles, assist in decreasing the self-stigma and perceived-stigma that mothers experience when living with postpartum emotional difficulties or PPD, provide mothers with the strength to build resilience within themselves, and encourage mothers to seek help from within and from others for the symptoms of postpartum emotional difficulties or PPD they experience.

My Reflections

Embarking on this research journey was both exciting and daunting. I felt excited to contribute to this field of research and to examine women's experiences with contemporary norms of mothering and help-seeking for their postpartum emotional difficulties. I knew this was an important phenomenon to study because of the reactions from family, friends, and people I

would meet when I discussed my thesis topic. Their reactions would range from "wow, that is such important research" to "I also experienced PPD and I didn't get help". The more I discussed my thesis topic with people, the more I realized that many women are struggling silently with postpartum emotional difficulties. Knowing this motivated me to continue with this research. After hearing from more women that they also experienced postpartum emotional difficulties I continued to wonder why is this not talked about more openly in society? The answer to that question is subjective, depending on the person you ask; but, for the four women in this research study, the main barrier was stigma.

Both analyzing the data and writing my findings in Chapter Four were exciting pieces of this research. I felt I had a duty to my participants to express their experiences and spread awareness about this phenomenon. The participants expressed how happy they felt that there was a researcher who was conducting research on postpartum emotional difficulties because they hoped that it would help other women who were also experiencing postpartum emotional difficulties. Since I have experienced postpartum emotional difficulties, I knew I had to practice careful bracketing and reflexivity throughout the analysis process. I continually reminded myself that the interview that I was reading was the participant's story, not mine, which allowed me to separate myself from the data and view it from a researcher's perspective. I continually engaged in self-care practices such as meditation, yoga, and walks to help me clear my mind and to allow me to understand the assumptions that I had on this phenomenon. I believe that having a clear mind helped me be aware of new and surprising findings.

As exciting as this research was, there were times that it was daunting. I knew I was at a place in my journey that I was no longer experiencing my postpartum emotional difficulties and I was removed enough from my experience to examine this phenomenon without having it bring me down emotionally. However, there were a few sections that were tough to write. Specifically, the section on the impacts that PPD have on the rest of the family. I knew it was important because it provided evidence towards why it is important that women get help when they experience PPD. However, it was hard because it made me wonder how my experience with postpartum emotional difficulties affected my husband and more importantly, my son. It brought on the feelings of 'mommy guilt', making me wonder if my son will experience difficulties in his life because of my experience when he was a baby. However, I reminded myself that I can't change my past; I can only focus on what I can do now to strengthen our bond. I also reminded

myself of the reasons why I was doing this research: In hopes that other women will be able to seek help for their postpartum emotional experiences and in hopes that this research will help break the stigma attached to postpartum emotional difficulties.

The inner strength and resilience that the participants developed as they moved through their challenges both inspires me and moves me. I remember leaving the interviews with the feeling of hope. I felt that if these women can build resilience and inner strength to help them cope with their postpartum emotional difficulties then their words and experiences could also encourage other moms to build resilience and inner strength to overcome their challenges. I'm proud to use their voices in this research and pass along both their challenges and their strengths to the general public. Through conducting this research and spreading awareness about postpartum emotional difficulties, I hope that more women will feel comfortable seeking help for their postpartum experiences.

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APPENDIX A: POSTER INVITATION TO PARTICIPATE

UNIVERSITY OF SASKATCHEWAN

Did you experience emotional difficulties following the birth of your child?

The purpose of this study is to explore women's experiences with social expectations of mothering impacting their ability to seek help. You are invited to participate in a research study titled *Help-Seeking Behaviours of Women Experiencing Emotional Difficulties Postpartum: The Impact of Contemporary Norms of Mothering.*

I am a graduate student in School and Counselling Psychology at the University of Saskatchewan, looking for women who meet the following criteria:

- a woman who is between the ages of 25-35
- gave birth to a healthy baby within the last five years
- not currently in a state of crisis;
- had any of the following experiences within the first year after giving birth:
    - depressed mood
    - excess weight gain or loss
    - sleep disturbances
    - fatigue
    - thoughts of suicide or death
    - anxiety,
    - low self-esteem
    - lack of sex drive
    - loss of interest or pleasure
    - loss of appetite
    - agitation
    - decreased concentration or ability to think
    - feelings of worthlessness, guilt, or hopelessness
    - anger or easily irritated
    - inability to cope
- have experienced social norms of mothering impacting their ability to seek help for emotional difficulties postpartum
- able to commit to one interview lasting approximately 60-90 minutes

If you are interested please contact Chandra Decae by email: cjh150@mail.usask.ca

Participants will receive an honorarium ($20 gift certificate) to offset the cost of parking and daycare.

This research project has been approved on ethical grounds by the University of Saskatchewan Research Ethics Board on June 26,	Emotional difficulties postpartum study Chandra Decae cjh150@mail.usask.ca	Emotional difficulties postpartum study Chandra Decae cjh150@mail.usask.ca	Emotional difficulties postpartum study Chandra Decae cjh150@mail.usask.ca	Emotional difficulties postpartum study Chandra Decae cjh150@mail.usask.ca	Emotional difficulties postpartum study Chandra Decae cjh150@mail.usask.ca	Emotional difficulties postpartum study Chandra Decae cjh150@mail.usask.ca	Emotional difficulties postpartum study Chandra Decae cjh150@mail.usask.ca

APPENDIX B: TELEPHONE SCREENING GUIDE

Researcher (R): Hi there, I received your email indicating your interest in participating in the study 'Help-Seeking Behaviours of Women Experiencing Emotional Difficulties Postpartum: The Impact of Contemporary Norms of Mothering'. Are you still interested in participating for this study?

1. R: I just want to confirm that you meet the criteria required. Are you between the ages of 25-35? Did you give birth to a healthy baby within the last five years? Are you currently in a state of crisis? Do you self-identify with having experienced PPD like symptoms in the first year after giving birth? (symptoms such as depressed mood, loss of interest or pleasure, excess weight gain or loss, loss of appetite, sleep disturbances, agitation, anger, or irritation, slowing of body movements, fatigue, decreased concentration or ability to think, thoughts of suicide or death, feelings of worthlessness, guilt, hopelessness, anxiety, low self-esteem, inability to cope, inability to confront day to day tasks, lack of sex drive)? Can you speak about your experience with social expectations of mothering impacting their ability to seek help for emotional difficulties postpartum? Are you able to commit to one interview lasting approximately 60-90 minutes

R: Great, then I invite you to participate in this study. I will be conducting one interview that will last approximately 60 to 90 minutes of your time.

R: I would like to set up a date and time for this interview. It will be held in room (#1219 or #1221) in the College of Education building.

If they don't fit criteria:

R: I'm looking for participants who do meet the criteria required and unfortunately you didn't meet criteria __(insert criteria not met)___. Thank you for your interest in the study. If you wish

to receive a copy of the results of this study, I will email you a debriefing form with both my email address and my supervisor's email address. Please contact us after June 1, 2016 for a copy of the final report.

If a participant indicates that they are currently in a state of crisis, they will be encouraged to seek support via counselling agencies and/or mobile crises listed on Appendix H: Counselling Services Sheet. Student-researcher will provide this list to the participant through email or verbally during the telephone screening phone call.

APPENDIX C: COUNSELLING SERVICES SHEET

UNIVERSITY OF SASKATCHEWAN

Help-Seeking Behaviours of Women Experiencing Emotional Difficulties Postpartum: The Impact of Contemporary Norms of Mothering

If you experience any feelings of depression, anxiety, or are feeling unsettled and would like to talk with someone, below is a list of support you can contact in Saskatoon:

Student Counselling Services
3rd Floor Place Riel
1 Campus Drive
(306) 966-4920
Fee: Free for U of S Students

Family Service Saskatoon
506 25th Street East
Saskatoon, SK S7K 4A7
(306) 244-0127
Fee: Sliding scale, based on income

Catholic Family Services
(306) 244-7773

The Saskatoon Health Region Postpartum Anxiety and Depression Support Group
Intake Nurse: 306-221-6806

Mental Health and Addictions Services
(306)-655-7950

Mobile Crisis
24 hour crisis phone line
(306) 933-6200
Fee: Free

APPENDIX D: CONSENT FORM

UNIVERSITY OF SASKATCHEWAN

Project Title: Help-Seeking Behaviours of Women Experiencing Emotional Difficulties Postpartum: The Impact of Contemporary Norms of Mothering

Researcher(s): Chandra Decae, Graduate Student, Department of Educational Psychology and Special Education, University of Saskatchewan, (306) 262-7726, cjh150@mail.usask.ca

Supervisor: Dr. Stephanie Martin, Department of Educational Psychology and Special Education, (306) 966-5259, Stephanie.martin@mail.usask.ca

Purpose(s) and Objective(s) of the Research:
The purpose of this research study is to explore how contemporary norms of mothering affect the experience of being a mother, the emotional difficulties that women experienced, and the help-seeking behaviours of women who have experienced emotional difficulties postpartum.

Procedures:
This study will consist of a semi-structured interview, meaning that I will have a list of questions that will be asked to allow you to speak to your experience with emotional difficulties postpartum, social expectations of mothering, and help-seeking behaviours. Since it is semi-structured, prompts and follow up questions may be asked, depending on the responses. Once the interview is complete, I will transcribe it. At this point, if you choose to review your transcripts, you will receive a copy via email. You can choose to add, delete, or alter any data as deemed necessary.

The interview will take place at the University of Saskatchewan, College of Education, room #1219 or #1221. The interviews will be audio recorded and then transcribed. Data from these recordings will be used for my (Chandra Decae's) thesis. Data from the interview may be represented in the thesis through direct quotations. However, any identifying information will be removed, except for your chosen pseudonym.

Potential Risks:
The risks associated with this study are below minimal risk. However, you may experience discomfort when discussing your experiences with emotional difficulties postpartum and social

expectations of being a mother. Painful memories may surface. However, you have the right to refuse to answer any questions that I ask and you have the right to stop discussing topics at any time. You have the right to ask that the audio recorder be turned off at any time. You will have the right to withdraw your participation at any time. If you experience any emotional discomfort as a result of your participation, a list of counsellors in the city of Saskatoon is attached to this document.

Potential Benefits:

There are potential benefits of this study, however, they are not guaranteed. Talking about your experiences you've had with the impact that social expectations of mothering had on your help-seeking behaviors for emotional difficulties postpartum may allow you to gain a deeper understanding of your experience. You participation may also help inform individuals in the helping profession who work with women who have had similar experiences.

Compensation:

Since the interviews will take place on the University Campus, the student-researcher will provide an honorarium ($20 gift certificate) to offset the cost of daycare, parking, etc.

Confidentiality:

The results of this study will be discussed in a thesis required for completion of a master's degree. The findings will be available to the public through the thesis data base. Any direct quote taken from the interview may be used; however, any identifying information will be changed and names will be replaced with a pseudonym of your choice. Audio recordings will only be accessible to the student-researcher and supervisor. You have a right to ask that the audio recordings be shut off at any time if you feel uncomfortable. Upon completion of the interview, the data will be transcribed by the student researcher. If you chose, I will email you a copy of your transcripts for you to read over via a password protected file. At this point, you can add, delete, or alter information from the transcript as you see fit.

Storage of Data:

At the end of the research project, the results and associated material (e.g., audio recordings and transcripts) will be securely stored on campus at the University of Saskatchewan by my supervisor, Dr. Stephanie Martin, for a minimum of five years. When the data is no longer required, all data will be destroyed beyond recovery.

Right to Withdraw:

Your participation is voluntary and you can answer only those questions that you are comfortable with. You may withdraw from the research project for any reason, at any time without explanation or penalty of any sort. Should you wish to withdraw, any information gathered will

be destroyed beyond recovery. Your right to withdraw data from the study will apply until analysis has begun. After this point, it is possible that some form of research dissemination will have already occurred and it may not be possible to withdraw your data.

Follow up:

Upon completion of the interview you will be given a debriefing form and a transcript release form. To obtain results from the study, please contact the student researcher, Chandra Decae, or supervisor, Dr. Stephanie Martin at the emails mentioned above.

Questions or Concerns:

If you have any questions regarding the study, feel free to contact either the student researcher, Chandra Decae, or the supervisor, Dr. Stephanie Martin at the numbers provided above. This research project has been approved on ethical grounds by the University of Saskatchewan Research Ethics Board. Any questions regarding your rights as a participant may be addressed to that committee through the Research Ethics Office ethics.office@usask.ca (306) 966-2975. Out of town participants may call toll free (888) 966-2975.

Consent:

Your signature below indicates that you have read and understand the description provided and have had an opportunity to ask questions and my/our questions have been answered. I consent to participate in the research project. A copy of this Consent Form has been given to me for my records.

There are a few options for you to consider if you decide to take part in this research. Please put a check mark on the corresponding line(s) that grants me your permission.

You may use direct quotations from my interview: Yes: ____ No: ____

The pseudonym I choose for myself is: _____

I would like to review the transcript of my interview: Yes:____ No: ____

_____	_____	_____
Name of Participant	*Signature*	*Date*

_____	_____
Researcher's Signature	*Date*

A copy of this consent will be left with you, and a copy will be taken by the researcher.

APPENDIX E: INTERVIEW GUIDE

Interview Questions:

1. Remember an experience where you encountered a social expectation of mothering. Can you tell me about this experience with as much detail as possible?

   Probes: What was the social expectation? What does social expectation mean to you? What was it like for you to be influenced by social expectations around mothering? What did this experience mean to you? How has this experience affected you?

2. Please share with me how this experience affected any emotional difficulties you experienced postpartum.

   Probes: What was your experience with emotional difficulties? What symptoms did you have? How did the emotional difficulties affect mothering for you? What did it mean to you to be experiencing emotional difficulties postpartum?

3. Please tell me about your experience with the decision to not seek help for your emotional difficulties.

   Probes: What specific social expectations were barriers to seeking help? How did the social expectations create a barrier to seeking help? What was it like to feel you couldn't seek help? Did these barriers affect your mothering? If so, in what way did they affect your mothering? What motivated you to keep going every day? How did you overcome the emotional difficulties you experienced despite the barriers you faced?

4. What would have helped you overcome these barriers in order to seek help for your emotional difficulties postpartum?

5. Is there anything else you think I should know about your experience with social norms impacting your ability to seek help for the emotional difficulties you experienced postpartum?

Other Probes that may be used:

- What was that like for you?
- Can you tell me more about that?
- What do you mean?
- Can you give me an example?
- What were you feeling at the time?
- What were your emotions?
- Can you describe that more?

Check-ins:

- How are you doing as you discuss this topic?
- Are you ok to continue with the interview?
- Are you ok to end the interview?

APPENDIX F: TRANSCRIPT RELEASE FORM

TRANSCRIPT RELEASE FORM

Help-Seeking Behaviours of Women Experiencing Emotional Difficulties Postpartum: The Impact of Contemporary Norms of Mothering

I,_____, have reviewed the complete transcript of my personal interview in this study, and have been provided with the opportunity to add, alter, and delete information from the transcript as appropriate. I acknowledge that the transcript accurately reflects what I said in my personal interview with Chandra Decae. I hereby authorize the release of this transcript to Chandra Decae to be used in the manner described in the Consent Form. I have received a copy of this Data/Transcript Release Form for my own records.

_____	_____
Name of Participant	Date
_____	_____
Signature of Participant	Signature of researcher